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A Hermeneutic Study of Service  
Improvement Experiences in Nursing:  
From Student to  
Newly Registered Nurse.

L. Craig.

Ph.D.

2017

**A Hermeneutic Study of Service  
Improvement Experiences in Nursing:  
From Student to Newly Registered  
Nurse**

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This thesis is submitted in partial fulfilment of the  
requirements of Northumbria University for Doctor of  
Philosophy degree

School of Nursing, Midwifery and Healthcare

**Lynn Craig**

April 2017



## **Abstract**

Service improvements in healthcare can improve service provision; make cost efficiency savings, streamline services and reduce clinical errors. However, service improvement alone may not be adequate in improving patient outcomes and quality of care. Complexity of healthcare provision makes service improvement a challenge, and there is little evidence of whether service improvement initiatives change healthcare practice and improve patient care. To equip the nursing workforce with the skills necessary to make service improvements, Higher Educational Institutions (HEI) have developed courses that include service improvement within their pre-registration programmes. However, service improvement is a learned skill, which nurses need to practice in order to become competent in making improvements.

In order to explore service improvement in nursing, hermeneutic phenomenology was used to gain an understanding of the lived experiences from student to registered nurse. A purposive sample of twenty participants were selected from an adult pre-registration nursing programme, during their third year. Data was collected using semi-structured interviews in two phases; once when the participants were student nurses and 12 months later when the same participants were registered nurses. Data analysis occurred using a van Manen (1990) approach and the hermeneutic circle to facilitate interpretation and analysis of findings. Four key themes emerged from the data; service improvement in nursing; socialisation in nursing practice; power and powerlessness and challenges in changing practice. Findings showed that the participants underwent processes of professional transformation, becoming empowered and developing resilience in making service improvements from student to registered nurse. Participants achieved this by developing positive, adaptive behaviours. A new '*Model of Self-efficacy in Service Improvement Enablement*' is presented which explains the participant's service improvement journey. This new model has relevance for both nurse education and practice, in seeking to improve patient care through service improvements in nursing.

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**Authors declaration**

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved.

Approval has been granted by the University Ethics Faculty Ethics Committee on 14<sup>th</sup> December 2012 and a local NHS Foundation Trust Research, and Ethics Committee 5<sup>th</sup> February 2013.

I declare that the Word Count of this Thesis is 75,456 words

Name: Lynn Craig

Signature:

## **Glossary of terms**

DH	Department of Health
GT	Guidance Tutor
HEI	Higher Education Institutes
KSF	Knowledge and Skill Framework
NPSA	National Patient Safety Agency
NHS	National Health Service
NHSIII	NHS Institute for Innovation and Improvement
NHS IQ	NHS Improving Quality
NMC	Nursing and Midwifery Council
PDSA	Plan, Do, Study, Act
UK	United Kingdom
USA	United States of America

## **Nurse Title and Grades**

Sister/ Charge Nurse	Grade 6/7
Ward Manager	Grade 7
Staff Nurse	Grade 5
Health Care Assistant	HCA

## **Chapter 1 Introduction to Thesis**

### **1.1 Introduction to chapter**

The doctoral research presented in this thesis provides an exploration of the experiences of service improvements in nursing, from student to newly registered nurse. From this exploration, a new model, explaining how the participants developed self-efficacy in making service improvements in nursing has been developed.

Service improvement is an important feature in United Kingdom (UK) healthcare (Christiansen & Griffith-Evans, 2010; Baillie, Bromley, Walker, Jones, & Mhlanga, 2014) and is recognised as a mechanism through which healthcare services can be improved, savings can be made and patient outcomes enhanced (Boaden, Harvey, Moxham & Proudlove 2008; Baillie et al., 2014). The complexity of care provision in the National Health Service (NHS), compounded with complicated care pathways and priorities of different stakeholders, make service improvements in healthcare a challenge (Boaden et al., 2008). Therefore, service improvement can only be successful if organisational strategy and culture promotes and encourages service improvements in practice through supporting healthcare staff to be involved in the process (Harvey & Kitson, 1996). However, it is not clear how healthcare staff are equipped with the skills necessary to make service improvements in the challenging context of the NHS (Marshall et al., 2013).

Service improvement in nursing is important in promoting high quality, safe and effective nursing care (Koivula, Paunonen, & Laippala, 1998; Wilcock & Carr, 2001; Christiansen & Griffith-Evans, 2010; Hewison, 2010) and is significant as nurses are the largest group of employees within the NHS (NHS Confederation, 2014).

However, many nurses fail to recognise development of service improvement skills as a fundamental aspect to their role (World Health Organisation, 2008) and they lack the knowledge and skills needed to make service improvements (Wilcock et al., 2009).

Preparation for service improvement should commence during initial nurse education and continue to post registration practice if nurses are to contribute to service improvement as part of their clinical practice (Wilcock & Carr 2001; Wilcock, Janes, & Chambers 2009; Kovner, Brewer, Yingrengreung, & Fairchild 2010). Embedding service improvement in pre-registration nursing programmes may help prepare registered nurses with the skills necessary to make service improvements in nursing and establish it as a fundamental component of their role (Christiansen & Griffith-Evans, 2010). However, a crucial factor in having registered nurses who are competent in making service improvements is a requirement for them to experience and practice service improvements in their nursing practice. Therefore, nurses need to be able to refine and develop their service improvement skills and practice within organisational staff development programmes (Wilcock & Carr, 2001; Ehnfors & Grobe, 2004 ; Christiansen & Griffith-Evans, 2010).

The purpose of this chapter is to set the scene for this thesis and provide a context for the research aim and questions. A definition of service improvement in nursing is provided for the purpose of this study. Service improvement in nursing and nurse education is briefly discussed in context of local pre-registration nurse education and provision. Finally, the research aim, objectives and questions are presented, alongside a brief overview of the research process. The chapter concludes with a synopsis of this thesis and provides a precis of the subsequent chapters.

### ***1.1.1 Defining service improvement in healthcare***

Finding a consensus of service improvement in healthcare and nursing is difficult (Jones et al., 2013).

A review of publications citing service improvement suggests its history within industry and healthcare is complex and that there is no consensus that supports a definitive description (O'Neill et al., 2011; Clarke, 2013; Jones et al., 2013). There is also a plethora of related terms used to describe service improvement in healthcare which are used interchangeably and mean different things in different contexts (Morrow, Robert, Maben, & Griffiths, 2012). Furthermore, the meanings and terminology used when describing service improvement in healthcare have changed over time (Jones et al., 2013). This may be a contributing factor why the NHS has historically had difficulty in adopting differing approaches in service improvement (Pollitt, 1993) as different groups define service improvement in different ways (Clarke, 2013).

In nursing, the terminology used to describe service improvement is variable and is interchangeable. Terms include quality assurance, total quality management, continuous quality improvement and practice development (Long 2003; Clark, 2013; Jones et al., 2013). The term quality improvement, for example, includes various different models, one of which is service improvement (Clark, 2013). Service improvement increasingly incorporates the term safety or has safety as an element within the definition (Boaden, Harvey et al., 2008). Despite this confusing picture of service improvement in healthcare, there are common themes associated with the definitions, including a commitment to benefit patients and to work and learn collaboratively in practice (Marshall, Pronovost, & Dixon-Woods, 2013).

One definition of service improvement describes a planned and targeted effort to improve patient outcomes from a service (Fitzgerald, Ferlie, McGivern, & Buchanan, 2013). However, this is a rather simplistic definition and does not encapsulate the complexity of service improvement in healthcare.

In order to provide a more comprehensive description for the purpose of this study, service improvement was defined as:

*“The combined and unceasing efforts of everyone to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) regardless of the theoretical concept or tool utilised”* (Batalden & Davidoff, 2007, p.2)

Batalden and Davidoff’s definition (2007) places service improvement in the centre of five knowledge systems including scientific evidence, context awareness, performance measurement, plans for change and execution of planned changes. This definition is comprehensive and encompasses the complexity and diversity of services within healthcare and nursing. It offers a holistic and philosophical view of service improvement, which is congruent to the aim and objectives of this study. Importantly this definition is cognisant of the learning and professional development which takes place in healthcare practice. It reflects an on-going, collaborative approach to service improvement and considers a desire for improved services, better outcomes of care and patient safety.

### ***1.1.2 A personal journey to service improvement understanding***

My experiences of service improvement in nursing have evolved throughout my professional career, from registering as a nurse in 1986, to the present day. Prior to being a senior lecturer, I was a Service Manager in the NHS. This was a challenging role, often with conflicting priorities including managing complex services, controlling budgets and leading staff. Senior nurses have to manage complex professional roles, which require them to both assess the quality of the services they provide and conduct research to generate new knowledge for the development of their clinical practice (Gullick & West, 2012). Service improvements were used to change service delivery, promote cost effectiveness and ensure appropriate use of resources. This was set within a NHS governance framework. Clinical governance comprises of a whole system approach to service improvement where

organisational leadership, culture and systems are central to achieving systematic quality improvement (Walshe, 2000). The responsibility and accountability for clinical governance is considered the business of all healthcare professionals at every level (Maddock, Kralik, & Smith, 2006) and it is committed to promoting safe, patient-centred services in clinical practice (Bishop, 2009).

The Knowledge and Skills (KSF) Framework was developed to ensure healthcare staff adopted six core components necessary for effective practice in the NHS. (Great Britain. Department of Health, 2003). These core components include communication, personal and people development, health, safety and security, equality and diversity and service improvement. Service improvement is therefore a core component of every job description used within in the NHS (Great Britain. Department of Health, 2003). Nurses should be working toward these components and see service improvement as fundamental to their role.

Nevertheless, my experiences highlighted differences in understanding, interest and motivation from nursing colleagues in making service improvements. It was apparent some nurses were eager to make service improvements. These nurses recognised the need for service improvements and wanted to improve services to patients; they were concerned by the perception that nursing was uncaring or too busy to make improvements. Other nurses appeared ambivalent about service improvement and disengaged with the concept. These nurses did not accept a need for service improvements, suggesting the service they delivered was effective and appropriate already. Some nurses expressed confusion with government policy requiring high quality services for patients, set in an environment where austerity measures and performance targets are perceived as barriers to service improvement. Several nurses described feeling pressured to meet key performance indicators rather than making improvements to the service they provided for patients.



This dissonance caused several nursing colleagues to feel frustrated as to how they could make service improvements.

As a senior lecturer, I had an opportunity to integrate my knowledge and experiences of service improvement in teaching the theoretical aspects as part of a pre-registration nursing programme. I taught the concepts of service improvement and assessed student nurses who had made service improvements as part of a module during their pre-registration programme. Through this process, I became aware of student nurse's perceptions and experiences of service improvement. Some student nurses were articulating similar concerns and challenges in making service improvements in nursing as my previous nursing colleagues had described in practice.

This was an interesting observation; I wanted to understand this phenomenon. How do student nurses and nurses' experience of making service improvements in nursing? What factors affect their learning and practice experiences of service improvements in nursing? What facilitates service improvement? What are the barriers to making service improvements? What can we learn about the experiences of nurses making service improvements in nursing? How can we better support nurses making service improvements? My curiosity and desire to answer these questions and understand this phenomenon became the motivation for this study.

### ***1.1.3 Introduction to service improvement***

The UK Department of Health (DH) has implemented a range of initiatives to promote service improvement in healthcare and the NHS (Christiansen & Griffith-Evans, 2010). These initiatives are set within a 'modernisation' agenda where service improvement is a mechanism for changing and improving healthcare provision (Mazur, McCreery, & Rothenberg, 2012; White, Wells, & Butterworth, 2014). However, service improvement is complex and resides in an ever changing healthcare arena; with limited financial resources,

an ageing population, advances in technology, financial pressures and a focus on improving patient care (Selman & Harding, 2010; Mitchell, 2013; Smith, Pearson, & Adams, 2014). Despite these initiatives, there is evidence that service improvements alone are not an effective means of changing practice and improving patient care (Harvey & Kitson 1996; Ovretveit & Gustafson 2002; White et al., 2014).

Nurse education has not previously equipped nurses with the skills required for service improvement (Wilcock & Headrick, 2000). For nurses to make service improvements, learning and practice should begin at university as part of pre-registration education (Wilcock & Carr, 2001). More recently, service improvement has become a feature in pre-registration nursing programmes. Student nurses identified this as being important in raising their awareness of service improvement in practice (Smith & Lister, 2011a; Jones, Williams, & Carson-Stevens, 2013). Despite, service improvement featuring in pre-registration programmes, some registered nurses still report feeling unprepared for service improvement in practice (Kovner et al., 2010). Exposure to service improvement must continue into post registration practice if nurses are to contribute to service improvement as registrants (Wilcock & Carr 2001; Wilcock, Janes, & Chambers 2009; Kovner, Brewer, Yingrengreung, & Fairchild 2010). Registered nurses require on-going education and practice of service improvement so that they can develop the necessary skills to enable them to make improvements in nursing practice (Ehnfors & Grobe 2004; Christiansen & Griffith-Evans 2010).

#### ***1.1.4 Local context***

This research occurred through a large University in the North East of England, which provides Adult Pre-Registration Nursing Programmes. At the time of this study, the Pre-Registration Nursing Programme was a three-year, undergraduate advanced diploma or degree pathway.

Pre-Registration nursing programmes encompass 50% theory and 50% practice components (NMC, 2010). Theoretical components take place at university during study blocks. All lecturers must comply with the Nursing and Midwifery Council (NMC) (Nursing Midwifery Council, 2008) Standards to Support Learning and Assessment in Practice and have a recorded NMC teaching qualification. Lecturers use classroom-based teaching, seminar and practical sessions to teach student nurses. Practice components occur when student nurses are on clinical placement. The term 'placement' describes the workplace-learning environment. This can be a hospital ward, specialist unit or community setting where the student is supervised by a registered nurse who is a recorded mentor. Mentors are registered nurses who have completed a NMC approved mentor preparation course as required in Standards to Support Learning and Assessment in Practice (NMC, 2008). Mentors provide support and guidance in the clinical area to support student nurses in meeting competencies in practice (Price, Hastie, Duffy, Ness, & McCallum, 2011). Student nurses are also supported in practice by academic staff who are link tutors in clinical practice. Link tutors provide support to students in meeting the NMC Standards for Pre-registration Nursing Education (NMC, 2010), linking theory and practice and consolidating their learning (Baillie et al., 2014).

The NMC Standards for Pre-Registration Nursing Education state:

*"All nursing students need to act as 'change agents', to enhance people's wellbeing and experiences of health care through leadership and quality improvement"*  
(NMC 2010, p.7)

The concepts of leadership, management and team working are competencies, specifically linked to quality and service improvement. As such, student nurses, mentors and academic staff are important allies in identifying and making service improvements in clinical practice (Jones et al., 2013).

Local university provision for Pre-Registration Nursing Programmes includes a 20-credit, module focussing on service improvement, which student nurses complete during semester two of their final year. The students attend university for six weeks and complete a module on service improvement, incorporating the theoretical principles and approaches to service improvement in healthcare. After completion of the module, the students return to clinical practice for eight weeks. During their practice, the students are required to identify and make a service improvement in nursing. The student's summative assessment considers application of the theoretical principles of service improvement and making changes in clinical practice.

#### ***1.1.5 Clarification of participant status during study***

All the participants in this study were from the adult field of nursing. Throughout this thesis, the participants are referred to as student nurses rather than adult student nurses. The other fields of nursing were not involved in this study. The decision to focus on adult nursing and the scope of this research is discussed later in Chapter 8 of this thesis.

Phase One of this study occurred when participants were in semester two of their third year pre-registration programme. Phase Two occurred 12 months later, when the same participants were newly registered nurses. This definition of newly registered nurses corresponds with The Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals, which defines:

*“‘Newly registered practitioner’ refers to a nurse, midwife or AHP who is entering employment in England for the first time following professional registration with the NMC (Nursing Midwifery Council) or HPC (Healthcare Professions Council)”*  
(Great Britain, Dept. of Health 2009, p. 6)

Throughout this thesis, the participants are referred to as registered nurses rather than newly registered nurses during Phase Two of this study.

## 1.2 Research aim, objectives and questions

The importance of service improvement in nursing has been explained. However, there is a gap in the current body of research and literature exploring service improvement in nursing. Having an understanding of factors that affect nurse's experiences of service improvements is essential for nurse education and practice, so that nurses can become enabled to make improvements. There are no longitudinal studies which have explored the experiences of service improvements from being a student to a newly registered nurse. I could find no research that explains how student and newly registered nurses adapt and become enabled to make service improvements in nursing practice.

Designing courses and continuing professional development are not sufficient in preparing nurses for service improvement, rather an understanding of the complexities of course processes, application of theory and outcomes in context of NHS organisational culture would help the understanding of how service improvement translates from nurse education into clinical practice (Walshe 2007; Wilcock et al., 2009; Johnson et al 2010).

In order to address some of the gaps in the existing body of research the overarching aim of this study was to provide:

*'An understanding of the lived experiences in making service improvements in nursing from student to newly registered nurses'*

To achieve this aim, a number of specific research objectives were identified:

- To investigate the lived experiences of nursing students in service improvement after they had completed a module on service improvement in university and clinical practice.
- To identify and explore factors, which influence nursing students' learning and experiences in service improvement practice.

- To understand how student nurses, adapt to being newly registered nurses in making service improvements in nursing practice.
- To identify strategies and behaviours which student and newly registered nurses utilise in order to make service improvements in nursing practice.
- To develop a new model of understanding how nurses make service improvements in nursing practice.

### ***1.2.1 Research questions***

In order to meet the aims and objectives of this study, the following research questions were developed:

1. *What are student nurses' experiences of service improvement in education and its application in clinical practice?*
2. *What are newly registered nurses' experiences of service improvement in clinical practice?*

## **1.3 Organisation of the thesis**

Chapter 1 frames this thesis and explains why service improvement is an important issue in nursing and nurse education. A definition of service improvement for this study is presented. Service improvement is located in the context of local pre-registration nurse education and nursing practice. Finally, the research aim, objectives and questions are identified.

Chapter 2 supports the introduction chapter and presents the literature review of this study. The literature review, based on the research aims, objectives and questions is presented. There was a systematic review and analysis of existing literature regarding service improvement in nurse education and practice. The literature review was expanded in order to support analysis of findings and inform the discussions later in this thesis.

Chapter 3 explores the conceptual framework used to inform the findings of this research. Theoretical concepts of social constructivism, power, social and adult learning theory and professional development are discussed. These concepts provide a theoretical lens which are explored in conjunction with an explanation of their influence on the findings of this study.

Chapter 4 details the research methodology chosen for this study. Different approaches to phenomenology are discussed and critiqued. A rationale for choosing hermeneutic phenomenology is provided and the methodology is aligned to the conceptual framework, which informed the analysis of findings in this study.

Chapter 5 provides an explanation of the phenomenological research process undertaken. This includes the sampling strategy, data collection and the method of data analysis. Ethical considerations are discussed. The use of the hermeneutic circle and a van Manen approach to data analysis are explored as ways to aid interpretation and analysis of findings.

Chapter 6 presents the findings and allows the reader to immerse themselves in the data generated. The findings are presented as four key themes and sub-themes using verbatim quotations in order for the individual participant voices to be heard. Each theme and sub-theme is discussed, drawing on published research and literature to explore the findings. From this analysis, initial theoretical development occurs in relation to processes that participants underwent as they experienced service improvement in nursing.

Chapter 7 revisits the conceptual framework that informed analysis of findings. Through using the hermeneutic circle, deeper interpretation of the findings occurred. The final stage of data analysis provided in-depth analysis of findings that illustrated how the participants adapted their behaviours in order to make service improvements in nursing. The participant's positive adaptive behaviours are applied to Banduras' (1997a) theory of Self-Efficacy.

The conceptual analysis of the lived experiences of student and newly registered nurses in service improvement in nursing has allowed for a new model of service improvement enablement to be developed.

Chapter 8 concludes this thesis. The unique contribution of this research to the existing body of literature is highlighted. Recommendations for pre-registration nurse education, nursing practice, future research and local NHS Trust policy are presented. The potential limitations are explored in context of the scope of this study. Finally, I provide a reflexive account of my research journey.



Figure 1 provides summary of the chapters contained within this thesis:

Figure 1 Summary of chapters

Chapter 1	<ul style="list-style-type: none"><li>•Introduction to Thesis</li><li>•Research aim, objectives and questions</li></ul>
Chapter 2	<ul style="list-style-type: none"><li>•Literature review</li><li>•Literature review of key concepts</li></ul>
Chapter 3	<ul style="list-style-type: none"><li>•Developing the conceptual framework</li></ul>
Chapter 4	<ul style="list-style-type: none"><li>•Research Methodology</li><li>•Interpretive paradigm</li><li>•Hermeneutic phenomenology</li></ul>
Chapter 5	<ul style="list-style-type: none"><li>•Research Methods</li><li>•Sampling strategy</li><li>•Data collection</li><li>•Data analysis</li><li>•Ethical considerations</li></ul>
Chapter 6	<ul style="list-style-type: none"><li>•Presentation of findings</li><li>•Summative discussion of findings</li></ul>
Chapter 7	<ul style="list-style-type: none"><li>•Discussion</li><li>•Presentation of new model of understanding</li></ul>
Chapter 8	<ul style="list-style-type: none"><li>•Conclusion</li><li>•Recommendations</li><li>•Limitations</li><li>•Reflexivity</li></ul>

## **1.4 Chapter conclusion**

This chapter has provided a definition of service improvement in the context of this research. The background of service improvement in nursing has been discussed briefly and this study is positioned in context of local provision of pre-registration nurse education. The research aim, objectives and questions have been identified. Finally, an overview of this thesis has been provided to structure and signpost the subsequent chapters.

The following chapter presents the literature review undertaken during this study and presents an analysis of the current literature relevant to this study's aim, objectives and questions.

## **Chapter 2 Literature Review**

### **2.1 Introduction to chapter**

In chapter 1 the background and context of this study was presented. The aim of this research was to provide a new understanding of service improvement experiences for student and registered nurses. This chapter presents a widespread literature review of relevant research and literature in the context of this studies aim.

The literature review was ongoing throughout the duration of this study. An initial literature review was undertaken focussing on the research questions and aim. This identified a gap in the existing body of knowledge of service improvement in nursing, which this study aims to address. The literature review expanded during the course of this thesis. After each phase of data collection, findings emerged as key themes and sub-themes. The literature review expanded to incorporate the emerging findings, themes and supported developing theoretical concepts. New literature and research was added to the initial literature review, to inform the interpretation, analysis and completion of this thesis.

### **2.2 Literature review: an ongoing process**

Literature reviews are essential in the research process (Wu, Aylward, Roberts, & Evans, 2012). They provide researchers with an understanding of how knowledge is created, demonstrate personal learning and the process of thinking and re-thinking (Whittaker and Williamson, 2011). A social constructivist approach acknowledges that the researcher enters the study with some existing knowledge and experience, which can influence and contribute to the construction of new knowledge. Indeed, in order to complete an initial research proposal (IPA) required for doctoral study, it is necessary for the researcher to demonstrate a level of underpinning knowledge which can justify their research proposal.

In this study the literature review was ongoing, undertaken; before (where the research aim and objectives of this study provided the focus), during (to incorporate current evidence) and after the research interviews (in order to inform analysis and findings) (Silverman, 2010).

A variety of different books, journals and electronic databases were used to access information. Theoretical sensitivity allows researchers relevant insight and understanding from reading appropriate literature from a comprehensive range of studies applicable to their current research aim (Silverman, 2010; Bettany-Saltikov, 2012; Aveyard, 2014). Aveyard, (2014) suggests researchers should structure their literature review by using a wide range of available sources from which to refine the literature search. For this study a range of electronic databases were utilised including:

- Northumbria University library search engine NORA
- Medline (EBSCOhost)
- Allied and Complementary Medicine Database (AMED)
- Health Management
- Health, Social Work and Education (HSWE)
- British Nursing Index (BNI) Cochrane Library
- Google Scholar
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Health Management
- House of Commons Parliamentary Papers
- Journals@Ovid Full Text

However, there are challenges with literature searches that use electronic databases. Search engines differ and journal archives may vary in how they are structured. Journals often use different terminology in their respective fields to represent the same idea and different index terms can affect search results (Wu et al., 2012). I therefore used different key words and truncations in order to expand the initial concepts and themes and refine the literature search.

Figure 2 illustrates the initial literature search fields based on the research aim and questions:

**Figure 2 Initial literature search strategy based on research aim and questions**

Initial literature search terms
<b>Service improvement</b>
1. Service improvement * AND nursing*
2. Service improvement* AND healthcare*
3. Service improvement* AND nursing students*
4. Service improvement * AND Registered nurses*
<b>Quality improvement</b>
1. Quality of care* AND service improvement
2. Patient safety* AND service improvement
3. Service improvement AND Improvement initiatives in healthcare* AND NHSII* AND UK*
4. Global service improvement AND Nursing*
5. Service improvement models * AND Approaches to service improvement in healthcare* AND UK*
6. Quality of care * AND service improvement *
<b>Service improvement in nurse education</b>
1. Pre-registration service improvement *
2. Socialisation * Nursing * AND nursing students*
3. Support mechanisms for student nurses* AND Mentors
4. Student nurses AND Practice learning * Learning environment*

Parahoo (1997) recommends defining a timeframe for the literature search. It is also important to clarify any inclusion and exclusion criteria in order to target the literature search (Bettany-Saltikov, 2012).

The inclusion criteria comprised of literature dated 1995-2016. However, I became aware that this period excluded some seminal texts, key theories and other relevant literature. Therefore, the criterion was extended, allowing their inclusion. The literature search was also widened to include international studies as well as those from the UK.

When reviewing research literature, a process of critical appraisal determined if the literature was appropriate, trustworthy and relevant to this study. Aveyard (2014) suggests eight steps that researchers can use when appraising literature:

1. Who wrote the paper?
2. Where was it published?
3. Is there a research question and is the methodology appropriate for addressing the question?
4. Was the right research methodology used?
5. What sample strategy for the study?
6. How big was the sample?
7. How was the data collected?
8. How was the data analysed?

The literature, references and citations were filleted (Silverman, 2010), meaning the abstracts were skim read to determine if the literature appeared relevant to this study. If the abstract was deemed appropriate, Aveyard's (2014) recommendations for appraisal were followed. Literature considered relevant to this study was accessed and read in full. By using this approach, texts were discriminated and selected as appropriate to this study.

### 2.2.1 Expansion of literature review

Figure 3 illustrates expansion of the literature review based on the emergent themes from the findings:

**Figure 3 Emerging themes from data collection and expansion of literature review**

Expansion of literature search terms
<b>Power, empowerment in nursing</b>
1. Power*, empowerment * AND nursing practice*
2. Power* AND Powerlessness* AND Empowerment* AND healthcare*
3. Powerlessness* AND Empowerment* AND nursing students*
4. Power* AND Registered nurses*
5. Self-belief*, Confidence* AND Empowerment *
<b>Practice based support</b>
1. Ward managers* AND Service improvement* AND Leadership * AND Learning environment*
2. Authority* AND Leadership*
3. Research link nurses*, Practice educators * AND service improvement
4. Service improvement AND Improvement initiatives in healthcare* UK* AND NHSII*
5. Global service improvement AND Healthcare* Nursing * UK*
6. Service improvement models * AND Approaches to service improvement in healthcare*
7. Quality of care * AND service improvement *
<b>Role transition</b>
1. Transition shock* AND Preceptorship*
2. Socialisation * Nursing * AND Registered nurses *
3. Support mechanisms for nurses* AND Preceptorship * Ward manager*
4. Adapting* Role transition * AND nursing
<b>Socialisation in nursing</b>
1. Nurses AND Practice learning *AND Learning environment*
2. Belonging* Fitting in* And Nursing practice * Learning environment
3. Confidence* AND Nursing
4. Culture* AND Ward environment * AND Nursing students * Nurses *
<b>Ritual and Routine</b>
1. Tradition and custom * AND Nursing
2. Culture AND Nursing *
3. Theory * Practice* AND Gap*

The expansion of the literature search allowed incorporation of new literature that was of interest for this thesis, generating questions, identifying new concepts and forming relationships (Silverman, 2010). This approach to assimilating findings with relevant literature is congruent with hermeneutic phenomenology (Draucker, 1999), which was the chosen methodology of this study. The literature was synthesised in order to inform analysis of findings (Silverman, 2010), which are discussed later in this thesis.

The literature search provided a large amount of material to manage. Books, research, policy and articles were originally stored in a bookcase and filing cabinet however, managing this volume of material in a systematic way became a challenge. In order to facilitate filing and retrieval of information, EndNote <sup>TM</sup> provided a single depository. EndNote <sup>TM</sup> facilitated referencing and developing a personal library in which to store, organise and retrieve literature during the writing of this thesis. EndNote <sup>TM</sup> saves articles and literature as PDF attachments, which were then easy to access when re-reading or citing in this thesis. Another benefit of using EndNote <sup>TM</sup> was a reduction of costs attributed to printing copies of articles and literature.

This part of the chapter explores the initial literature review and later expansion, allowing a context from which to discuss the findings later in the thesis. The literature review in the next section is presented thematically as new concepts emerged during the research process.

### **2.3 Service improvement in healthcare**

In order to understand service improvement within healthcare it was necessary to explore the historical, global and national context of service improvement and how the NHS has adopted service improvement in the UK.



### ***2.3.1 A historical and global context of healthcare service improvement***

Service improvement in healthcare is not a new concept and can be traced back to the 1900s when the first clinical audits in healthcare occurred (Boaden et al., 2008). However, the drive for service improvement has become increasingly important at a global and national level during the past twenty years and healthcare professionals have experienced significant development in this area (Long, 2003; Batalden & Davidoff, 2007; Christiansen & Griffith-Evans, 2010; Baillie et al., 2014).

Feigenbaum (1961) developed total quality control, which was described as an effective system for integrating quality and service improvement. This approach to service improvement was essentially a business method with three steps to quality including leadership, modern technology and organisational commitment (Feigenbaum, 1961). Japanese industry developed the concept of service improvement during the 1980s. Ishikawa (1985) added to service improvement with a focus on *kaizen*, a Japanese word that translates as continuous management. Ishikawa believed in the human side of quality and viewed improvements as being the individual responsibility of every member of staff (Ishikawa, 1985).

The 1980's saw service improvement established in healthcare. This advance saw business and industrial approaches to service improvement being introduced within clinical environments in an attempt to address gaps and improve healthcare provision (Boaden et al., 2008).

The United States of America (USA) and Australia developed departments for service review and improvement within healthcare organisations and institutions (Long, 2003). The Institute of Healthcare Improvement (USA) published 'Crossing the Quality Chasm: A new Health System of the 21<sup>st</sup> Century (Institute of Medicine, 2001) which outlined

changes and service improvements required in healthcare to cope with the needs of the population (Locock, 2003).

The Australian Council for Safety and Quality in Healthcare similarly set out plans for radical reforms in their healthcare systems (Australian Council for Safety and Quality in Health Care, 2003). However, initiatives for service improvements in healthcare are not restricted to these countries. In the UK, there has been a growing emphasis on service improvements in healthcare and the NHS.

### ***2.3.2 United Kingdom service improvements in healthcare***

Service improvement has been a priority for successive UK Governments. The DH founded the NHS Institute for Innovation and Improvement (NHSII) to promote modernisation of healthcare and facilitate service improvements (Bate, Robert, & Bevan, 2004). The National Patient Safety Agency (NPSA) (2004) recognised service improvement and patient safety as part of the modernisation process for the NHS (National Patient Safety Agency, 2004). Clinical errors and adverse events present serious risks to patients' safety and healthcare professionals must strive for service improvement as a means of promoting patient safety (Kyrkjebo, 2006). The service improvement agenda was based on improving healthcare services, making cost efficiency savings, promoting healthcare outcomes and ensuring patient safety (Boaden et al., 2008). 'High Quality Care For All' positioned service improvement as integral to NHS reforms (Great Britain. Department of Health, 2008). This policy set out provision for healthcare staff to use their expertise, creativity and skills in order to make changes in practice, which improved the quality of care to patients. Features required for service improvement included effective leadership, a shared vision, different methods of improvements and high expectations (Great Britain. Department of Health, 2008). The 'Improvement Leader's Guide' was introduced with a range of toolkits designed to support staff in improving their services and promoting patient safety, experience and outcomes (NHS Institute for Innovation and Improvement, 2008c).

‘NHS 2010–2015: From Good to Great. Preventative, People-centred, Productive’ (Great Britain. Department of Health, 2009) aimed to improve patient care and safety through service improvement initiatives. This policy suggested:

*“Convenience for the system too often takes precedence over convenience for patients. There is still too much variation in the quality and safety of care. Improvement must be accelerated to ensure that the NHS is fit for the new era”*  
(Great Britain. Department of Health 2009, p.9)

The DH has actively encouraged all NHS organisations to make service improvement part of their core business (Christiansen & Griffith-Evans, 2010). ‘Equity and Excellence: Liberating the NHS’, outlined a five year vision for the future of the NHS (Great Britain. Department of Health, 2010a). The UK government proposed that savings made through service improvements were reinvested in frontline services in order to enhance the care of patients. Further to this, ‘The Nursing Road Map for Quality’ set out a vision for high quality health care with patient services focused on outcomes and quality standards (Great Britain. Department of Health, 2010b).

The government drive for service improvement has seen a plethora of more recent initiatives including the ‘NHS Safety thermometer’ (Great Britain. Department of Health, 2012), ‘Energise for Excellence Vision’ (NHS Institute for Innovation and Improvement, 2012), ‘Harm Free Care’ (NHS Institute for Innovation and Improvement, 2013a), ‘High Impact Actions for Nurses and Midwives’ (NHS Institute for Innovation and Improvement, 2013b) and ‘The Productive Series’ (NHS Institute for Innovation and Improvement, 2013c).

In 2013, NHS Improving Quality (NHS IQ) became the lead agency for service improvement across the NHS in England. In November 2015 the NHS IQ was absorbed into a ‘Sustainable Improvement Team’ with key objectives for service improvement including patient safety, management of long term conditions, promoting life expectancy and supporting NHS change. All these service improvement initiatives can be seen as a

modernisation agenda where healthcare provision is moving from a low-cost model of healthcare to a new model, which encompasses continuous service improvement (Mazur et al., 2012; White et al., 2014). Such approaches to service improvement have the potential to improve healthcare, utilise resources more effectively and produce practical learning.

Nevertheless, service improvement alone may not be adequate in improving patient outcomes and quality of care (Varkey, Reller, & Resar, 2007). There is a paucity of evidence showing whether service improvement policies and initiatives have had an impact on changing practice and improving patient care. Rather, there is evidence that healthcare services are failing to deliver on basic standards of care, performance targets and patient expectations (Harvey & Kitson, 1996; Ovretveit & Gustafson, 2002; Francis, 2013; White et al., 2014). Furthermore, tools such as the 'Safety Thermometer' (Great Britain. Department of Health, 2012), are yet to prove they improve quality of care for patients (Buckley et al., 2014).

These business-like approaches to service improvement have failed to account for the complexity of healthcare systems and have been rejected by staff as being management fads (Pollitt, 1996; Shafer & Aziz, 2013). Service improvement is a challenging process, set within a complex context of healthcare requirements which have a greater emphasis on quality and safety (Granger et al., 2012; Shafer & Aziz, 2013), yet are constrained by limited financial resources and ever changing health care policies (Selman & Harding, 2010). The Operating Efficiency Framework warns the NHS is about to enter its toughest ever financial climate (Burgess & Radnor, 2012). Shafer & Aziz (2013) argue that service improvement will not be accomplished by using, what some staff view as gimmicks or fads. White et al., (2014) argue that nurses should be concerned about the effect and impact new systems of work may have on front-line teams. Technological advances, an aging population and a focus on improving patient experiences, require a determined response

from nurses who are working in an environment characterised by budgetary constraints (Selman & Harding, 2010; Smith et al., 2014).

It is in this complex environment that nurses are expected to make service improvements. In order for service improvements to occur, they must take place within an organisational strategy and culture which promotes and fosters improvements in practice through enabling healthcare staff to be involved in the process of change (Harvey & Kitson, 1996; Shafer & Aziz, 2013). Nevertheless, it is unclear how healthcare staff are equipped with the skills necessary to make service improvements (Marshall et al., 2013).

#### ***2.3.4 Service improvement models in healthcare***

Nurses require an understanding of different models of service improvement, which they can utilise when making changes in practice. However, service improvement models are often determined at an organisational level rather than by the individual making the changes (Berwick, 2004) and where the choice of the approach is dependent on the nature of the improvement project (Varkey et al., 2007).

The Plan, Do, Study, Act (PDSA) model of service improvement and organisational change was widely adopted by UK healthcare in the 1980s (Deming, 1986; Varkey et al., 2007; Baillie et al., 2014). Demming (1986) suggested healthcare staff could make service improvements in different settings and recognised the complexity of factors, which affect how improvements occur. The PDSA model was later expanded for its application in healthcare to eight domains which included; healthcare as a system, measurement and variability, collaboration and accountability, leading following and making changes (Batalden, Splain, Baker, Bisognano, & Headrick, 1998). Boaden et al., (2008) argue that whilst PDSA is an older service improvement model, there is no evidence that newer approaches are more effective. Nevertheless, how the service improvement model is implemented is more important than what model is utilised (Boaden et al., 2008).

‘Lean’ is a newer service improvement model which supports day-to-day working, change and improvements in healthcare (Womack & Jones, 2005; Burgess & Radnor, 2012).

There are five principles to Lean including; value from the customer, value for each product and challenge wastage, making flow continuously without interruptions, letting the customer pull value from the producer and the pursuit of perfection (NHS Institute for Innovation and Improvement, 2008c). Despite Lean being highly regarded within healthcare, it may not be able to overcome the challenges in service improvement, with conflicting priorities between service provision and budgetary constraints (Burgess and Radnor, 2012). A review of Business Process Improvement Methodologies carried out on behalf of the National Audit Office (UK) found 51% of publications sourced Lean as a service improvement model. In the NHS, 40% of hospitals were found to use Lean for service improvements (Burgess & Radnor, 2012; White et al., 2014). This has relevance for this study, as student nurses and nurses are likely to encounter these service improvement approaches during their education and nursing practice in the NHS.

### ***2.3.5 Quality of care and service improvement***

Poor quality of care was brought to the fore when Mid Staffordshire NHS Trust was criticised for failings in care provision and preventable patient deaths (Francis, 2013). The Francis Report (2013) stated that the Executive Board and NHS systems in Mid Staffordshire focused on financial matters ahead of the quality of care and was critical of a top-down NHS management style. Ultimately poor leadership and a failure to develop the right culture of care was identified as a key factor (Francis, 2013). There were 290 recommendations made in an effort to address the shortfalls in quality and safety of patient care (Francis, 2013). The Keogh Review (2013) further highlighted concerns regarding standards of patient care in some hospitals (Keogh, 2013). Reasons for poor care are complex but include financial challenges and insufficient staff (Keogh, 2013). ‘Francis Report; One year On’ highlighted that although a positive start had been made by many

NHS Trusts in implementing Francis' recommendations (Thorlby, Smith, Williams, & Dayan, 2014), concerns remained that many recommendations had not been adopted and the NHS had not improved the culture regarding patient safety and quality of care (Tingle, 2014).

Following publication of the Francis Report (2013) and negative media coverage, nurses have been perceived being uncaring and as delivering poor standards of care (Aiken, 2014; Hardacre, 2014). Nurses have been accused of lacking compassion and of having lost sight of the values and principles that underline healthcare delivery (Tetley, Dobson, Jack, Pearson, & Walker, 2016). Nurses have expressed concerns about their ability to deliver a high quality service and argue that increasing patient complaints and negative press reports are warning signs that austerity measures may be risking harm to patients, rather than these being an indication of uncaring nurses (Aiken et al., 2014). Service improvements in nursing not only improve patient care but also undo the negative perceptions which nursing has experienced (Aiken et al., 2014).

## **2.4 Service improvement in nurse education**

Service improvement should be an integral part of all nursing care delivery (Gage, 2013) and the benefits of educating health professionals in service improvement has been recognised (Ling, Soper, & Buxton, 2010). Nevertheless, nurse education lacks an emphasis on the skills required for service improvement (Wilcock & Headrick, 2000). Service improvement within pre-registration curricula is a major factor in helping nursing students acquire the knowledge and skills needed for service improvement in practice (Wilcock & Lewis, 2002). Nurses should be prepared during pre-registration education and supported during post registration practice if they are to contribute to healthcare systems that consider service improvement integral to practice (Wilcock & Carr, 2001; Wilcock et al., 2009; Kovner et al., 2010). Several studies have explored the involvement of student nurses in service improvement (Hanssen and Haugland, 2001; Wilcock and Lewis, 2002;

Kyrkjebo & Hage, 2005; Kyrkjebo, 2006; Christiansen & Griffith-Evans 2010; Smith and Lister, 2011a; Baillie et al., 2014).

Service improvement is a learned skill and student nurses need to be supported and given the opportunity to implement their service improvement ideas (Smith & Lister, 2011b). Service improvement has not been an integral part of pre-registration healthcare programmes until recently (Smith & Lister, 2011a) and there is little research exploring how nursing students experience service improvement learning within university and in the practice environment (Christiansen & Griffith-Evans 2010; Baillie et al., 2014). This remains the case, with Jones et al., (2013) suggesting this raises the issue of how service improvement is taught to students in both education and practice.

#### ***2.4.1 Pre-registration service improvement learning in the UK***

Service improvement has recently become established in pre-registration health programmes in the UK (Christiansen & Evans, 2010; Smith and Lister, 2011). The NHSIII commissioned Higher Educational Institutes and local NHS organisations to develop courses that included service improvement within the undergraduate healthcare curricula. ‘Improvement in Undergraduate Education for better, safer healthcare’ (NHS Institute for Innovation and Improvement, 2008a) was developed to enable students to acquire understanding and practice of service improvement in healthcare.

‘Evaluation of the Improvement in Pre-registration Education Programme: Final Report’ (NHS Institute for Innovation and Improvement, 2008b) reported positive evaluations of service improvement in pre-registration healthcare programmes. In pilot studies, 88% of nursing students who had undertaken service improvement as part of their pre-registration education, felt service improvement was important for their professional development. Of these, 94% believed service improvement was important to patient safety (NHS Institute for Innovation and Improvement, 2008b). Student nurses increased their knowledge and



skills in service improvement through being involved with the process and valued this experience (Mulready-Shick, Kafel, Banuster, & Mylott, 2009).

Johnson et al., (2010) found nursing students could apply the theoretical learning of service improvement into their practice. In their study, some nursing students were not always able to influence changes in practice. Students encountered barriers which prevented service improvements from progressing including resistance by staff; a perceived lack of time and the lack of student status within the workforce (Johnson et al., 2010). Despite these findings, nursing students found classroom-based preparation sessions using tools for service improvement such as Plan, Do, Study, Act (PDSA) were beneficial and that they had knowledge of these approaches to service improvement (Smith et al., 2014, Baillie et al., 2014).

Johnson et al., (2010) completed a pilot study on service improvement education for health professionals including nursing, physiotherapy, occupational therapy, social work and operating department practitioners. Using questionnaires, they concluded 90% of students thought service improvement was relevant to their careers. Smith and Lister (2011) found nursing students also valued service improvement learning as part of their pre-registration programmes and were able to identify areas for service improvement in practice. Students have reported that exposure to service improvement learning is significant to raising their awareness of this in clinical practice (Jones et al., 2013). Using qualitative content analysis, Machin & Jones (2014) found that service improvement in pre-registration learning had a positive impact in preparing students for life as registered professionals.

Smith et al., (2014) found that student nurses, who were introduced to service improvement during their pre-registration education, were positive about making changes during their clinical placements. Students expressed having a valid contribution to make through service improvement in clinical practice (Smith et al., 2014). Baillie, et al., (2014) had similar results using a multi-method case study approach; student nurses were positive

about service improvements in practice. Machin and Jones (2014) found students were able to identify themes of service improvement and complement organisational aspirations for high quality, safe and holistic care.

## **2.5 Nursing practice and service improvement**

Christiansen & Griffith-Evans (2010) used a cross-sectional survey which found that pre-registration nursing programmes encompassing service improvement, helped prepare registered nurses to make service improvements in nursing practice. However, registered nurses must experience and practice service improvement during their nursing practice in order to develop their skills (Wilcock & Carr, 2001; Ehnfors & Grobe, 2004; Christiansen & Griffith-Evans, 2010). The World Health Organisation (2008) suggested that some nurses fail to recognise the development of service improvement skills as a fundamental aspect to their role and lack the knowledge and skills needed to make service improvements (Wilcock et al., 2009). Kovner et al., (2010) carried out a qualitative study which found 39% of registered nurses felt poorly prepared for service improvement in practice, with some nurses reporting not even hearing of the concept. Therefore, nurse-led service improvements require knowledge and skills that are taught and practiced in order to be successful (Wilcock & Carr, 2001; Christiansen & Griffith-Evans 2010).

Organisational culture and leadership are crucial for service improvements to take place in healthcare (Boaden et al., 2008) and need to facilitate the concept through embedding core values of change (Christiansen & Griffith-Evans, 2010). There are a range of initiatives developed to support the capability of the healthcare workforce in driving forward a service improvement agenda and facilitating change in practice (Christiansen & Griffith-Evans, 2010). However, some healthcare staff make distinctions between service improvement and performance outcomes, which they consider are separate activities with differing priorities (Gollop, Whitby, Buchanan, & Ketley, 2004).

Whilst healthcare organisations aim to serve patients in practice, they do not always put the patient's needs before organisational convenience or requirements (Locock, 2003; Francis, 2013).

Some healthcare staff are sceptical of service improvement initiatives and see them as a distraction from their focus of providing care. Some staff view service improvements as being motivated by policy; focusing on productivity, at the cost of quality care and the patient experience (Gollop et al., 2004; Morrow et al., 2012; Burgess & Radnor, 2012). Arguably, staff within the NHS have become management facing rather than customer facing; where they respond to management requirements in the form of internal measures and targets rather than customer requirements (Burgess & Radnor, 2012). Some healthcare staff reject service improvement initiatives believing the government or senior managers impose them and that they have little opportunity to influence them (Pollitt 1996; Gollop et al., 2004; Shafer & Aziz, 2013). Locock (2003) suggests front line staff should lead service improvements as they know the position and can be creative in developing ideas. Through combining service improvement with individual and clinical priorities and working in partnership, service improvement has the potential to benefit patient care and clinical outcomes (Shojania & Grimshaw, 2005)

Studies exploring service improvement have identified a range of factors that influence how registered nurses make improvements (Koivula, Paunonen and Laippala, 1998; Locock 2003; Mowles, Gaag and Fox 2010; Baillie et al., 2014). Prerequisites to service improvement include education, a positive ward culture, effective team working and the involvement of clinical staff and senior management (Koivula et al., 1998; Locock, 2003; Watts, Robertson, Winter, & Leeson, 2013). White et al., (2014) suggest that human factors are a key feature in service improvement implementation and successful change in practice. Mazur et al., (2012) suggest healthcare managers do not always provide their employees with the learning and experience necessary to develop a culture of service improvement.

The balance between clinical priorities versus the need to invest time and resources into embedding service improvement in the culture is undoubtedly a difficult challenge (Burgess & Radnor, 2012). Therefore, service improvement in healthcare requires a substantial shift so all that parts of the system engage with changes. These changes include how service improvement is taught and facilitated in clinical practice (Batalden & Davidoff, 2007).

Whilst service improvement education may have an impact on knowledge and confidence, the effect on behaviour seems to be small and evaluating its impact in clinical practice is elusive (Wilcock et al., 2009). Nurses have complex professional roles that include undertaking research, evaluating the quality of services they deliver and generating new knowledge (Gullick & West, 2012). There are very few published evaluations of the application of service improvement learning in clinical practice for newly registered nurses (Baillie et al., 2014). Nurses must be committed to learning appropriate tools and acquiring the knowledge and skills of service improvement so they can teach and mentor other staff. However, nurse-led service improvement is a slow process, which involves a change in ward culture that only occurs over time (Shafer & Aziz, 2013).

Walshe (2007) suggests research exploring service improvement should not determine whether it works, rather when, how and why; unpicking the complexities of context, content, application and outcomes. Wilcock et al., (2009) agree and suggest designing courses and continuing professional development is not sufficient to embed service improvement in nursing. An exploration of the social context and mutual interdependence of service improvement is required. Johnson et al., (2010) recommend further research regarding course content and NHS organisational culture to help explore the application of service improvement theory from pre-registration programmes education into clinical practice.

## **2.6 The student nurse practice learning environment**

The importance of the practice-learning environment in nursing has long been recognised (Orton, 1981; Midgely, 2006; Kay, 2015). Practice learning is complex (Jantzen, 2012) and there are many factors which contribute and impact how student nurses learn (Salamonson et al., 2015). These factors include staff and student nurse relationships, the commitment of the manager, patient-nurse relationships, student satisfaction, hierarchy and ritual (Dunn & Hansford, 1997). Positive factors for student nurse learning include effective mentorship, role modelling, having responsibility, trust and being able to reflect and consider different viewpoints (Koontz, Mallory, Burns, & Chapman, 2010). These factors can have a profound impact on the student's ability to learn effectively in clinical practice (Koontz et al., 2010; Salamonson et al., 2015).

Practice learning environments can also be contentious and conflicts within them can place students under stress and disillusionment (Spouse, 2000b). Andrews et al., (2006) argue that the structure and placement of nurse education, which now resides in university rather than hospital based schools of nursing, has caused tensions between many university and non-university educated nurses. They suggest long-standing nurses whose training occurred in traditional hospital-based nursing schools, sometimes do not see the relevance of higher education for nurses and reject the academic content of nurse education. Long-standing nurses may feel side lined from past educational responsibility as students now learn predominantly within university settings (Andrews et al., 2006).

The complexity of learning in practice means student nurses need to develop an awareness of differing interpretations of nursing amongst those delivering health care; this awareness is an essential part of developing professional competence (Hunter & Krantz, 2010). Thomas, Jack and Jinks (2012) found that student nurses are affected by the reality of clinical practice and develop an early impression of the ward.

Students may have had organisational experiences before they began their nurse education and these experiences influence their perceptions of the practice-learning environment (Tomietto et al., 2014). The practice environment is pivotal to how nurses learn (Midgley, 2006) and is recognised as a key factor in how nurses are socialised (Melia 1987; Gray and Smith, 1999; Mackintosh, 2006; Levett-Jones & Lathlean, 2009; Kay 2015).

### ***2.6.1 Socialisation and the culture of nursing***

There has been a plethora of research exploring socialisation in nursing (Melia, 1987; Gray and Smith, 1999; Mackintosh, 2006; Levett-Jones & Lathlean, 2009; Dinmohammadi, Peyrovi & Mehrdad, 2013; Houghton, 2014; Kay 2015). Socialisation is the process through which new staff develop knowledge, attitudes and behaviours in order to effectively integrate within organisations and to successfully complete the transition from outside to inside in the workplace (Van Maanen & Schein, 1979). In nursing, socialisation is the process nurses go through in order to develop their professional identity (Dinmohammadi, Peyrovi, & Mehrdad, 2013).

Arguably, socialisation starts as soon as nursing students enter the profession and continues to be a feature for them throughout their careers (Dinmohammadi et al., 2013; Kay, 2015; Strouse & Nickerson, 2016). Nurses acquire knowledge, skills, attitudes, beliefs, values, norms and ethical standards so they can fulfill their professional role. Social constructivists suggest the concepts of socialisation and culture are closely linked and that both are socially created (Gray & Thomas, 2005). In nursing, socialisation occurs through social interactions with colleagues in clinical practice and can have both positive and negative consequences concerning the development of the nurses (Gray & Smith, 1999; Mackintosh 2006; Kay 2015). Socialisation is an ongoing process; a feature of lifelong learning, which some people adapt to more quickly and successfully than others (Weis & Schank, 2002).

The most important form of professional socialisation takes place in an institutional context including educational institutions, hospitals and healthcare providers where individuals learn and develop their profession practice (Alexandra, Eirini, & Maria, 2013). Education in nursing highlights the need for student-centred learning taking place in a positive social environment (Kala, Isaramalai, & Pohthong, 2010). Student nurses experience nursing practice in a variety of clinical placements during their three-year programme and are therefore exposed to on-going socialisation throughout their programme and are frequently a newcomer to the clinical environment (Houghton, 2012; Tomietto, Rappagliosi, Sartori, & Battistelli, 2014). Student nurses can be overwhelmed by the realities of clinical practice and may experience culture shock when moving between academic and practice environments (Dalton, 2005; Strouse & Nickerson, 2016).

The practice environment contributes to student nurse's socialisation through development of knowledge of organisational life by the means of written and unwritten norms (Tomietto et al., 2014). Nursing students socially connect and learn socialisation skills required in order to engage in relationships with patients and colleagues (Benner, Sutphen & Day, 2010). The culture of nursing arises from student's socialisation and exposure to differing values, morals, attitudes, beliefs, religious practices, language and behavioural patterns. Nursing culture is attached to each individual, sharing a background with others in the group and includes features of learned behaviour (Marzilli, 2014).

Working with mentors in clinical practice is the most powerful influence on how students are socialised and how well they adapt to the clinical culture (Rush, McCracken, & Talley, 2009). Dinmohammadi et al., (2013) found positive role models and good practice experiences contributed to the effective socialisation of student nurses. Houghton (2014) argues that central to socialisation is the concept of role modelling. Modelling occurs during social interactions through effective mentorship, which help student nurses fit in and develop the skills necessary for professional practice (Houghton, 2014).

Strouse & Nickerson (2016) identified conditions that assist students to adapt to the culture of nursing. These include positive learning experiences, role models and mentors. Social aspects of culture, including organisational hierarchies, power, historical considerations, interpersonal relationships and educational influences are also considered important factors in socialisation of nurses (Strouse & Nickerson, 2016).

Despite much literature professing the importance of positive socialisation, there is little guidance about how to safeguard against the impact of negative socialisation in nursing (Mackintosh, 2006; Levett-Jones & Lathlean, 2009; Dinmohammadi et al., 2013; Houghton, 2014; Kay, 2015). Negative consequences of poor socialisation include nurses who are not being able to demonstrate critical awareness of professional practice; perpetuation of ritualised practice and traditional views; developing significance for an assumed set of professional nursing values; the loss of idealism and acceptance of sub-standard practices (Mackintosh, 2006; Levett-Jones & Lathlean, 2009; Houghton, 2014). Francis (2013) highlighted concerns about the culture of organisations, a continuation of poor practice and a lack of standards for patient care and protection. If nurses are unable to recognise a need for service improvements or are unable to make changes in practice this may have a negative impact on patient care.

Socialisation is an on-going complex process that continues when nurses are registered (Dinmohammadi et al., 2013; Kay, 2015; Strouse & Nickerson, 2016). Newly registered nurses encounter a complex and demanding transition to practice. Student nurse experiences are important in how readily they adapt and socialise in the workplace as registered nurses (Tomietto et al., 2014). Kelly (1999) found that newly registered nurses are caught in tensions between two socialising forces, namely the academic and the real world of nursing. As nurses are socialised into nursing practice they become responsible for patients as well as having to learning different formal and informal rules and regulations of the organisation (Maben, Latter, & Clark, 2006).



Newly registered nurses learn to fit in by becoming chameleons, a process involving ongoing change; adaptation to new environments; adopting team values and norms and modifying their behaviours in order to be accepted (Levett-Jones and Lathlean, 2009). This process of socialisation is described as difficult for newly registered nurses with most experiencing a heavy workload and less support due to low staffing levels (Feng & Tsai, 2012).

In order to address some of the concerns regarding how nurses are socialised into the culture of nursing and understand the relevant implications for service improvement, those involved in both practice and university settings need to understand the complexities and work collaboratively (Strouse & Nickerson, 2016). It is important to recognise the vulnerability and uncertainty that nurses feel when dissonance is experienced between professional ideals and practice reality (Curtis, Horton, & Smith, 2012). Chesser-Smyth and Long, (2013) suggest Bandura's (1971a) Social Learning Theory has much to offer nurse education. Through using Bandura's (1997a) identified sources of self-efficacy, this can reduce the impact of negative socialisation (Chesser-Smyth and Long, 2013).

## **2.7 Supportive mechanisms for service improvement learning in nursing practice**

There is a considerable body of research exploring support in the learning environment for student and newly registered nurses (Pearcey & Elliott, 2004; Gibbons, Dempster & Moutray, 2011; Thomas, Jack, & Jinks, 2012; Grobecker, 2016).

### ***2.7.1 The role of the mentor in supporting student nurses***

This study explores the experiences for participants, from nursing student to registered nurse. As such, mentoring is an aspect of their pre-registration experiences. In practice-oriented professions such as nursing, the role of staff in supporting and teaching students is acknowledged (Bahn, 2001; Koontz et al., 2010; McIntosh, Gidman, & Smith, 2014;

Rush et al., 2009). Features which impact student learning in nursing practice are complex and include staff and student relationships, mentor support, demands of nursing activity and the constant pressure of time (Dunn & Hansford, 1997; Neary, 2000; Koontz et al., 2010). Benner et al., (2010) found the relationship between nursing staff and students is crucial because the former's interactions can help or hinder students clinical practice experiences. The main source of stress for student nurses relates to their clinical practice experiences (Gibbons et al., 2011; Thomas et al., 2012).

Mentors who are registered nurses, holding a NMC recognised teaching qualification (NMC, 2008) support student nurses in practice. All nurses have a responsibility to educate as part of their role and must:

*“Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues. Support students’ and colleagues’ learning to help them develop their professional competence and confidence”* (NMC 2015, Section 9-9.4)

Knowles's (1979) adult learning theory would categorise the role of mentors as a teacher who facilitates and supports learning as required. Evidence suggests that the relationship between student nurses and mentor changes over time. As student nurses reach the end of their pre-registration programme they begin to distance themselves from mentors 'moving from tasks to be learnt' to 'thinking about patients holistically' and the support they need in practice is reduced (Gray & Smith, 1999; Andrews & Roberts, 2003).

Positive relationships between student nurses, mentors and ward staff is the single most influential aspect of a positive learning experience (Cahill, 1996; Rush, McCracken, & Talley, 2009). Student nurses measured the success of their placements by the nature of their relationships with mentors and their amount of involvement with patients (Williams, 2012). A good mentor was seen as utilising every opportunity to create and maximise learning through their interaction and discussions (Neary, 2000).

Being understood by mentors; encouraged to learn and having responsibility, were fundamental to a positive learning experience (Bradbury-Jones et al., 2007). Favourable practice experiences were a key determinant of a successful education and student nurses highlighted the importance of positive mentoring in their experiences (Andrew, 2013). The same might apply to service improvement learning.

However, mentor relationships can also be a source of stress and anxiety for some students; causing some to feel stressed and disillusioned, describing negative attitudes from staff (Mamchur & Myrick, 2003; Spouse, 2000b; Pearcey & Elliott, 2004). Student nurses reported negative experiences with mentors, which increased their insecurities on their ability to accomplish tasks. They had little contact with mentors, lacked guidance and feedback and were left feeling frustrated (Landers, 2000; Andrews et al., 2006). Some students reported anxieties when staff were overly critical; appeared to have favourites, were fickle in their responses and were unwelcoming (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). Students described poor mentorship, where the mentor was overly either protective or, alternatively, 'threw them in the deep end' (Houghton, 2012). Failure to match up to the expectations of ward staff regarding nursing skills was also a concern for student nurses (Neary, 2000).

Nursing students have expressed a need for support, respect and acceptance and mentors are fundamental in providing this through support, feedback and supervision in clinical placement (Gray & Smith, 1999). Research has shown that student nurses recognise low staff morale, time pressures and feelings of negativity in clinical placements, all of which may negatively impact their confidence and ability to learn (Gibbons et al., 2011; Thomas et al., 2012; Grobecker, 2016). Mentoring is complex and involves the development of difficult and focused relationships in order to be successful (Gilmore & Kopeikin, 2007). Many nurses have mentoring imposed upon them as part of their role and job description

rather than having a real desire or ability to be a mentor (Andrews & Roberts, 2003) and there is insufficient mentor training and preparation (Henderson & Eaton, 2013).

Mentors are expected to undertake a variety of clinical activities, including service improvement, as well as facilitating student learning in practice. Nevertheless, not all nurses are suited to mentoring given the complexity of the role and the increasing demands of practice (Andrews & Roberts, 2003). Evidence suggests that as a result, some mentors feel ill prepared for the role and lack confidence in their ability (Huybrecht et al., 2011; Henderson & Eaton, 2013). Some mentors do not always fulfil their professional responsibility in educating students and find it difficult to interact positively with them (Evans and Kelly, 2004). Inadequate preparation for their role as mentor, alongside pressures of service delivery and low staffing levels have compromised the standard of learning which mentors can offer students (Evans and Kelly, 2004). Koontz, Mallory, et al., (2010) found some mentors lacked confidence when teaching students as they had professional insecurities when faced with challenging situations (Koontz, Mallory, et al., 2010). In addition mentors who were are stressed and felt overworked perceived students as a problem or additional burden (Andrews, Brodie, Andrews, Thomas, & Wong, 2005).

In order to be an effective mentor, nurses require professional and personal characteristics including clinical competence and knowledge; an ability to develop effective relationships with students, appropriate teaching and assessment strategies (Gignac-Caille & Oermann, 2001). Students nurses stated that mentors who offered them assistance and guidance had the most important personal characteristics and described enthusiasm; a positive attitude, clinical knowledge and a willingness to spend time with students and share their experiences as valuable attributes (Huybrecht, Loeckx, Quaeyhaegens, De Tobel, & Mistiaen, 2011). Research has shown that student nurses found effective mentors were positive role models and this enhanced their learning (Elcigil & Sari, 2008; Koontz et al., 2010). Role modelling is important in nursing with Benner (1984) suggesting observing

and emulating effective role models, it is the ideal way for nurses to learn, which includes observing service improvement practice.

Positive role modelling has an impact on how student nurses learn and develop self-efficacy (Bahn, 2001). Bandura (1971a) highlighted the importance of positive role modelling in that:

*“Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them of what to do. Fortunately, most human behaviour is learned observationally through modelling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action”*  
(Bandura 1977a, p. 22).

Therefore, mentors who are working with students must be aware of their impact as role models (Bahn, 2001). Huybrecht et al., (2011) argue mentors should only be appointed when they have acquired necessary skills and experience and that they should be willing and enthusiastic about teaching students.

### **2.7.2 Belongingness in nursing**

An important part of socialisation in nursing is a sense of belonging. Belonging is widely accepted in social theory, anthropology and psychology (Maslow, 1968; Baumeister & Leary, 1995). Maslow (1954) theorised a five-level hierarchy of needs. Maslow (1954) suggests an individual's most basic needs are survival, the need for air, food, clothing and shelter. Higher needs include safety and security, love and belonging, self-esteem and self-actualisation. Belonging is having social contact with others, being accepted and feeling an integral component of the group (Maslow 1968; Baumeister & Leary 1995). Baumeister & Leary (1995) argue belongingness is a fundamental component of humankind, where people discover stability, acceptance and are able to form resilience.

Several studies have shown that a sense of belonging is a fundamental need for student nurses and can have a positive impact on their learning, motivation and confidence (Levett-Jones & Lathlean, 2008; Houghton, 2014; Grobecker, 2016).

Student nurses attribute a sense of belonging to how well they fit in the team; are accepted, feel valued, trusted and respected (Burns & Paterson, 2005; Bradbury-Jones, Sambrook, & Irvine, 2011; Luanaigh, 2015). A sense of belonging is essential for effective learning (Ashktorab et al., 2015). If the psychosocial needs of learners are not addressed, then this can manifest in an inability to cope with the demands of education (Freitas & Leonard, 2011). Several studies have shown that when student nurses feel welcomed and have a sense of belonging they felt able to ask more questions and developed effective patterns of communication (Levett-Jones & Lathlean 2009a; Levett-Jones, Lathlean, Higgins & McMillan, 2009b; Spouse, 2000a). Students report a sense of belonging enhanced their learning and they were more likely to engage in ward activities, which is likely to include service improvement of some kind. Many student nurses reported that a need to belong and to fit in was more important than their nursing experiences (Levett-Jones & Lathlean, 2008).

Luanaigh (2015) found students sensed belonging when nursing colleagues were willing to spend time teaching them and considered this professional kindness and validation that their student role was respected. Students described this as being 'safe'; where they felt included, connected and secure (Luanaigh, 2015). Levett-Jones et al., (2009b) found self-efficacy in nursing students was strongly influenced by individual personality traits, previous experiences and the degree of belongingness that students experienced while on placement. Student nurses who demonstrated self-efficacy were more confident and capable in engaging with the clinicians and in negotiating learning opportunities in placements (Levett-Jones et al., 2009b). This will be of relevance when negotiating service improvement learning opportunities. Research has shown a lack of belonging and not

fitting in can lead to negative consequences for students where their learning can be adversely affected; they may suffer low self-esteem, self-defeatism and psychological distress (Levett-Jones & Lathlean 2008; Levett-Jones et al., 2009a, Levett-Jones et al., 2009b).

Not all student nurses fit in to the clinical area and have a sense of belonging. Students who do not fit in or experience a sense of belonging have reported feelings of fear and shame; they remained isolated and on the outside of the clinical team and were reluctant to initiate independent learning activities or challenge accepted ward practices (Spouse, 2000a). Some nursing students feel alienated from the nursing team when there is a negative attitude from some staff towards them (Bahn, 2001).

Student nurses work hard to fit in and gain a sense of belonging and conform in order to cope with becoming a nurse and achieve their goal of registering (Melia, 1982; Gray & Smith 1999; Levett-Jones et al., 2009b). Students describe a willingness to learn the routine and 'muck in' as strategies to gain a sense of belonging, acceptance by ward staff and achieve satisfactory reports from the ward manager (Melia, 1982; Gray & Smith 1999). This remains the same, where within the hierarchy of nursing culture, students can become accustomed to do and say what is expected; conforming as opposed to questioning and accepting rather than debating (Levett-Jones et al., 2009b; Thomas et al., 2012). Levett-Jones & Lathlean (2009b) found that student nurses were socialised to respect authority, follow instruction and show loyalty to the team. Other studies have shown that student nurses felt reluctant to ask anything more than basic questions in fear they receive an unfavourable response and they would cause trouble by asking the wrong questions (Levett-Jones and Lathlean, 2008; Kyrkjebo & Hage, 2005; Thomas et al., 2012). Unwelcoming experiences and responses from colleagues prevent nursing students from developing critical thinking skills as they do not want to risk making mistakes in front of staff (Levett-Jones & Lathlean, 2008). These findings are a concern as students nurses have

conveyed compliance with unacceptable nursing practices because they are reluctant to endanger their precarious sense of belonging (Levett-Jones et al., 2009b; Houghton, 2014). This phenomenon was more common in students who felt less secure of their place in the nursing team.

Levett-Jones et al., (2009b) found conformity as a way to improve a student's chance of belonging and reduce the risk of rejection, potentially having an adverse effect on service improvement learning.

An interesting observation is that despite student nurses valuing a sense of belonging they still retained their own ideas and values until such time as these could be implemented (Kelly, 1991; Gray & Smith, 1999). Students strongly believed that when they registered they would do things differently from what they had observed and experienced as student nurses (Kyrkjebo & Hage, 2005). Nixon (2014) found it was difficult for student nurses to speak up about negative experiences in clinical practice and many choose not to. Any negative feedback especially within smaller organisations was perceived as affecting their future job prospects. With increasing competition for a limited number of new nursing positions student nurses did not want to be seen as troublemakers (Nixon, 2014). Houghton (2014) and Luanaigh (2015) found it important that a sense of belonging is important beyond being a student and forms an important part of on-going professional development as a registered nurse. As this study was longitudinal and followed the participant's from being student to newly registered nurses, this was an important concept.

### ***2.7.3 Senior staff in the learning environment***

Sister, Charge Nurse and Ward Manager are terms used interchangeably in nursing and they indicate a level of seniority and authority. In this study the terms sister, charge nurse and ward manager describe nursing staff that have senior managerial responsibility for the ward or clinical area. They are responsible for organisation and delivery of patient care,



learning environments and the management of staff and students within their practice environment (Pegram, Grainger, Sigsworth, & While, 2014).

The role of the ward manager in nurse education has been examined for many years (Orton, 1981; Fretwell, 1982; Ogier, 1986; Dunn & Hansford, 1997; Hepner & Hopkins, 2000; McGowan, 2006; Koontz et al., 2010; Shafer & Aziz 2013). Ward managers have leadership skills and qualities, which reflect care standards and are important in creating and maintaining a conducive service improvement, learning environment (Orton, 1981; Fretwell, 1982; Shafer & Aziz, 2013), developing effective relationships within the team and encouraging professional development (Neary, 2000; Hepner & Hopkins, 2000).

Research has shown that ward managers are key in ensuring student nurses have a positive learning experience and they have the ability to affect team cohesion and create a positive learning environment based on trust and respect (Dunn & Hansford, 1997; Welsh & Swann, 2002; Mamchur & Myrick, 2003; McGowan, 2006; Koontz et al., 2010). Programmes designed to develop leadership skills for ward managers include how they can promote positive learning environments (Webb & Shakespeare, 2008). Ward manager leadership skills are significant in improving the culture for individual and collective learning, which benefits patients and promotes job satisfaction (Coventry, Maslin-Prothero, & Smith, 2015). However changes to the role can prevent ward managers from having a more direct input in student learning (O'Driscoll, Allan, & Smith, 2010) and this may reduce their efficacy as role models (Carlin & Duffy, 2013).

As well as being important in ensuring a positive learning environment, ward managers are required to promote service improvement as an integral part of nursing care (Gage, 2013). Gollop et al., (2004) found active engagement and leadership at senior levels was crucial to the long-term success of service improvement. Leadership, team working and effective communication are amongst the most important elements for making change in nursing (Mitchell, 2013).

Service improvement in nursing relies on leadership roles that are underpinned by positive relationships in the team (Fitzgerald et al., 2013). Ward managers and change agents are needed to encourage staff to participate in service improvement and support a ward culture where the voices and views of all staff are acknowledged as valuable (Shafer & Aziz, 2013).

Research has shown that nursing students and registered nurses need support from the ward manager in order to learn and contribute to service improvement in practice (Wilcock & Headrick, 2000; Wilcock & Carr, 2001; Wilcock, Janes, & Chambers, 2009; Kovner, Brewer, Yingrengreung, & Fairchild, 2010). Effective leadership is crucial in nurse-led service improvement models as ward managers are seen as coaches, supporters, mentors and preceptors for staff who are considered innovators (Shafer & Aziz, 2013). The relationship between the ward manager's leadership and managerial style is important in ensuring practice changes that improve patient care despite clinical pressures including staffing levels, capacity, and workload (Coventry et al., 2015). The importance of the ward manager in sustaining change in practice is necessary. Gollop et al., (2004) found active engagement and effective leadership at senior levels was vital in securing the success and longevity of service improvement initiatives.

#### ***2.7.4 Role transition and preceptorship***

Role transition is a relevant concept to this research as this study is longitudinal and involves the participant's experiences in service improvement in nursing during their role transition from student to newly registered nurse. There is a plethora of literature exploring role transition (Kelly, 1996; Treadwell, 1996; Bahn, 2001; Chang & Hancock, 2003; Duchscher, 2008; Duchscher, 2009).

Role transition for new graduates is the process of acculturation, of moving from being a newcomer to becoming an insider (Treadwell, 1996).

Role transition begins during pre-registration nurse education and continues for the first year following registration (Duchscher, 2008). This involves three stages of doing, being and knowing. 'Doing' involves how nurses adapt as they learn. 'Being' highlights how nurses start to search, question, examine and doubt. 'Knowing' concerns how nurses explore; critique and accept practice (Duchscher, 2008). During this process, nurses undergo a nonlinear developmental experience, which moves them through a range of professional, personal, intellectual, emotional, and relationship changes (Duchscher 2009).

Role transition has been described as challenging and traumatic with newly registered nurses experiencing difficulties, confusion and shock (Kelly, 1996; Bahn, 2001; Duchscher, 2009; Rush et al., 2009; Pennbrant et al., 2013). Kelly (1996) identified stressful experiences of newly registered nurses as they tried to socialise into the hospital culture in order to cope with fitting in the working environment. Bahn (2001) described role transition as a reality shock experienced by some newly registered nurses as they move from university into the clinical environment. Newly registered nurses are required to develop working relationships, prioritise workload demands and organise clinical priorities (Schoessler & Waldo, 2006). They often encounter a gap between knowledge acquired in initial nursing education and the complex knowledge demands in clinical practice and many lack confidence in clinical skills (Chang & Hancock, 2003; Hatlevik, 2012).

For newly registered nurses to navigate role transition there is a need to engage in learning both clinically and educationally. Support is a key factor and can occur in formal settings including university and within clinical practice. Nurse educators need to ensure strategies are in place to support newly registered nurses during role transition that focuses on emancipating them to know themselves and develop a realistic sense of self-competence (Kelly, 1996; Duchscher, 2009). Koontz et al., (2010) found nurses who had positive mentoring experiences as student nurses, often felt a commitment to give back to the nursing profession through being positive mentors themselves.

The NMC recommends all newly registered nurses undertake a period of preceptorship when they start working as registered nurses (NMC, 2006). Preceptorship is defined as:

*'A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning'* (Department of Health, 2010c, p. 11)

Preceptorship supports newly registered nurses to cope with the stresses of role transition and facilitates confidence, knowledge and skills career development (Marks-Maran et al., 2013; Lewis & McGowan, 2015). Preceptorship is linked to the Knowledge and Skills Framework (KSF) (Great Britain, Department of Health, 2003) through a supportive framework (Great Britain. Department of Health, 2010c). Preceptors support newly registered nurses, in a similar way to mentors. A recent study found newly registered nurses identified preceptorship as the mechanism which facilitated them developing confidence and resilience (Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016). Newly registered nurses suggest key features of successful preceptorship include managerial support, recognition for the roles of preceptor, protected time for interactions and educational preparation for preceptors (Whitehead et al., 2016). Houghton (2014) found role modelling is central to workplace socialisation and this occurs through preceptorship models of supervision that help newly registered nurses fit in and develop the skills necessary for professional practice. A poor experience during role transition can delay newly registered nurses reaching their full potential with some newly registered nurses feeling so overwhelmed they may leave the profession (Edwards, Hawker, Carrier, & Rees, 2015).

## **2.8 Personal characteristics for service improvement learning and practice**

Service improvement is just one of many challenges nurses will encounter during their pre-registration learning and post-registration nursing practice.

Nurses have to contend with a multitude of challenges including staff shortages, high patient expectations, technological advances, regulatory requirements, physical and psychological demands and ethical dilemmas (Hart et al., 2014). Nurses require many personal and professional characteristics in order to cope with these challenges.

### ***2.8.1 Resilience in nursing***

Resilience is an important concept in nurse education and practice (McAllister & Lowe, 2011; Stephens, 2013; Hart et al., 2014; Thomas & Revell, 2016). Nevertheless, a definition of resilience is still not clear in nursing literature (Stephens, 2013; Thomas & Revell, 2016). Resilience is how a person recovers from setbacks, copes successfully despite adverse circumstances and shows a sense of self-determination (Dyer & McGuinness, 1996; Hart, Brannan, & De Chesnay, 2014). In essence, resilience is:

*“How a person adapts to adversity and can be both developed and learned”*  
(McAllister & Lowe, 2011, p. 6)

Resilience is an essential skill which nurses require in order to contextualise and understand their experiences and to moderate their reactions to stressors faced in the clinical environment, preparing them for the challenges of nursing practice (McAllister & Lowe, 2011; Thomas & Revell, 2016). Nursing is a stressful profession and is known for high rates of staff turnover, absenteeism and burnout (Koen, Eeden Van, Wisslng, & Koen, 2011). Hart et al., (2014) postulates if nurses have difficulty coping with today’s pressures then new graduates are even more at risk for burnout. Student nurses experience high academic stress and are exposed to challenging situations such as death and dying, often for the first time (Thomas & Revell, 2016). Stephens (2013) suggests student nurses develop resilience individually, through a process of personal protective factors, which they use to navigate perceived stress and difficulties. Through increased success, nursing students develop enhanced coping and adaptive abilities.

Protective factors identified in the concept of resilience include being optimistic, having a sense of humour, being flexible and developing self-efficacy (Thomas & Revell, 2016). The impact of positive mentoring relationships; work-life balance, personal growth and professional reflection are factors which can enhance resilience in nurses (Jackson, Firtko, & Edenborough, 2007). In order to support nurses in developing service improvement capability, nurse educators are in the ideal position to assist them to develop resilience to cope with the challenges and adversities they may face in academic and nursing practice (Stephens, 2013).

### ***2.8.2 Confidence and self-efficacy in nursing***

Confidence underpins a nurse's competence to carry out care effectively and is closely linked to the concepts of self-efficacy and empowerment (Crooks et al., 2005). Student nurses who lack confidence may find it more difficult to fit in with colleagues, leading to them feeling unprepared for the challenges of nursing practice (Levett-Jones et al., 2009b; Grobecker, 2016). Research has shown that student nurses who lack support in practice, lack confidence and have difficulty in working relationships Grobecker (2016). When nursing students are supported by work colleagues, they adapt more easily and socialise more effectively which has a positive impact on building confidence (Wieland, Altmiller, & Dorr, 2007). Nursing students develop confidence through clinical practice; by positive mentoring experiences, peer support and success in practice (Levett-Jones et al., 2009c; Chessier-Smyth & Long, 2013).

Self-efficacy relates to a person's sense of confidence, their self-belief and ability to perform or to accomplish a goal or task in a given situation (Bandura, 1997a,b; Potter & Perry, 2001; Snyder & Lopez, 2007). In nursing, self-efficacy is dynamic and influenced by environmental experiences, differing, depending on the task in hand (Levett-Jones et al., 2009b; Gibbons et al., 2011; Chessier-Smyth & Long, 2013). Bandura (1997a) discuss

four sources of self-efficacy which are essential for effective performance (Ferrand, McMullan, Jowett, & Humphreys, 2006). Bandura (1997a) found high levels of self-efficacy produces doing behaviour in those individuals who perform successfully. People with high self-efficacy believe they are capable of accomplishing their goals and are willing to pursue them despite of difficulties they may encounter (Levett-Jones et al., 2009b). Mastering experiences and being successful is the most effective way in which self-efficacy can be increased (Taylor & Reyes, 2012). The sources of self-efficacy can have a positive influence on the development of self-confidence in students (Bandura, 1997a). However, if the task is too simple for the individual then self-efficacy can decline (Taylor and Reyes, 2012). Individuals who have experiences of failure may be deterred and their willingness to persist and become self-effective can be affected (Bandura 1997a, b). Nevertheless, Bandura (1997a) found that even if an individual receives negative feedback, their persistence and motivation can increase if they perceive the situation is an achievable challenge.

### ***2.8.3 Lifelong learning in nursing***

My study was longitudinal and explored the experiences of participants in service improvement from student to registered nurse; as such, the participants were exposed to the concept of lifelong learning during this study. The NMC (NMC 2008; 2015) requires nurses to engage in lifelong learning as part of their role in delivering evidence based nursing care and are required to demonstrate ongoing learning as part of NMC revalidation (NMC, 2015). The concept of lifelong learning is discussed extensively within nursing literature (Gopee, 2002; Gopee, 2005; Jarvis, 2005; Benner, Sutphen & Day, 2010; Davis & Easton, 2010, Davis et al., 2014).

Lifelong learning is defined as:

*“The development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments”* (Longworth & Davies 2003, p.22)

Benner et al., (2010) found lifelong learning is as an important feature in professional development and is an essential component in high quality patient care (Gopee, 2002; Davis, Taylor, & Reyes, 2014). Nurses undertake lifelong learning throughout their professional careers to achieve higher levels of practice through competent, proficient and expert levels. Davis et al., (2014) found lifelong learning enables nurses to develop over a period, where they move beyond accessing information and become questioning and reflective; open to new perspectives and ideas (Benner et al., 2010). Nurses' satisfaction may be enhanced through lifelong learning as they develop confidence, clinical ability and skills that are apparent to patients, families and other health practitioners (Eason, 2010).

Lifelong learning is complex and there are a range of psychosocial and environmental factors which impact the learner (Harlen & Deakin Crick, 2003). Gopee (2005) developed a conceptual framework for lifelong learning that encompasses organisational, socio-political and personal factors. An organisational and social working culture that recognises the importance of lifelong learning is receptive to learning and values a sense of belonging (Eason, 2010). Gopee (2002) suggests formal processes to support lifelong learning as well as informal social mechanisms and personal factors, can positively influence learning in nursing. Professional learning is self-instigated and enhanced through social interactions and support from other healthcare professionals. These characteristics establish features of social networks which enable individuals to work together more effectively to pursue shared objectives (Putnam, 1993).



## **2.9 Barriers to making service improvements**

In order to make service improvements nurses must be able to change nursing practice. However, change in nursing is a complex and challenging process (Shafer and Aziz, 2013). Change exists in an environment where increasing treatments costs; staff shortages, professional standards, regulatory requirements, increased technology and an ageing population are all features which add to the complexity of change (Selman & Harding 2010; Smith et al., 2014). These factors are often combined with other challenges including poor communication, demotivated staff and inadequate leadership (Mitchell, 2013).

Shafer and Aziz (2013) found that nursing staff demonstrate different levels of engagement in service improvement. Staff described how exposure to constant improvement projects and frequent failures contribute to decreased staff morale and create resistance to future change efforts (Shafer and Aziz, 2013). Clinical areas frequently repeat this pattern and create a culture that is increasingly resistant to change. Melnyk, Fineout-Overholt, & Gallagher-Ford, (2012) found barriers to service improvement included resistance by nurse managers, complex hospital politics and organisational cultures that avoided change. Staff learn to expect a return to the status quo and when that happens, they feel validated for refusing to participate or support change efforts; therefore, improvement efforts are rarely sustained. (Shafer & Aziz, 2013). In order for nurses to engage in and address the challenges and barriers to service improvement, nurses must have an understanding of the theoretical underpinnings of nursing practice.

### ***2.9.1 Theory practice gap in nursing practice***

Several studies found service improvement learning in pre-registration programmes can help students acquire knowledge and understanding of service improvement in nursing practice, making the link between service improvement theory and practice (Kyrkjebo et al., 2005; Kyrkjebo and Hage 2005; Johnson et al., 2010; Jones et al., 2013; Smith et al.,

2014; Baillie et al., 2014). However, there is a perceived gap between theory and practice in nursing (Cook, 1991; Landers, 2000; Maben, Latter & Clark, 2006; Hatlevik, 2012). Early authors suggested that attempts to close the theory practice gap were doomed to failure as they are based on an inadequate understanding of why the theory practice gap exists (Cook, 1991).

Dale (1993) argued there is not a gap between theory and practice, rather there is a theory-theory gap, exacerbated by a lack of experiential knowledge. Using nursing theory acquired during educational programmes in nursing practice is a difficult task because the different contexts, cultures and models of learning all have an effect on the application of theory in clinical practice (Eraut, 2006). Newly registered nurses are faced with professional and organisational sabotage that leaves them trying to make sense of theory and practice, often with little support and a lack of good role models to help (Maben, Latter & Clark, 2006). Lander (2000) suggests nurse teachers need to link theory to practice and assist learners to recognise the theoretical constructs that underpin their developing nursing practice. Hatlevik (2012) proposes a vital step in bridging the theory practice gap in nursing, may be through developing coherence between theoretical and practical components of initial nurse education.

### ***2.9.2 Nursing routine and ritual***

There has been an extensive research exploring ritual and routine in nursing practice which remains a common phenomenon in nursing practice today (Walsh and Ford, 1989; Kelly, 1996; Roberts, 2003; Thomas et al., 2012; Hutchinson & Jackson, 2016). However, the terms routine and ritual are often used interchangeably in nursing and this has resulted in a lack of understanding of the beliefs which underpin them (Rytterström, Unosson, & Arman, 2011; Hutchinson & Jackson, 2016). Walsh and Ford (1989) were critical of nursing routine and rituals; arguing nurses completed tasks in a routine way rather than thinking them

through in an analytical manner. Care may be harmful when it is carried out in an unthinking, routine and ritualistic way (Walsh and Ford, 1989). Kelly (1996) found newly registered nurses experienced pressure to conform to ward routines despite feeling these interfered with time they could have interacting on a more personal level and meeting patients' individual needs. This remains the same, Rytterström et al., (2011) found nursing routines often focus on accomplishing tasks rather than activities developed from a caring perspective.

Despite this concern about nursing routines, many routines have been retained as a characteristic in some clinical environments (Kerr, Lu, McKinlay, & Fuller, 2011). Some nursing routines have been preserved and reinforced in an unchanging form partly due to the nurse education system (Kerr et al., 2011). Thomas et al., (2012) found that poor teaching in clinical practice has led to the next generation of nurses adopting the same practices. This is problematic for service improvement, which by its very nature involves change and is disruptive.

Nursing rituals are more symbolic where the commitment to perpetuate the ritual is affective and ongoing (Rytterström et al., 2011). Kelly (1996) cautioned an unquestioning conformity to social norms results in the perpetuation of nursing rituals which are ineffective and may actually be destructive. Hutchinson & Jackson (2016) found many aspects of nursing care is perceived as groundless, based on unthinking, repetitive actions which lack any empirical basis (Philpin, 2002). Nursing rituals are often perceived in a negative way and are condemned through a lack of acceptance that some aspects of ritual nursing practice may be thoughtful or necessary (Roberts, 2003; Parissopoulos, Timmins, & Daly, 2013). Despite this, nursing rituals may provide a rich source of insight into the meanings attached to nursing care (Philpin, 2002). Negative connotations attached to nursing rituals may limit the view that some nursing rituals are useful or could be developed to incorporate valuable elements of nursing practice (Parissopoulos et al., 2013). The

current health care philosophy is one which encourages innovation, change and improvement (Great Britain. Department of Health, 2010a). Many nursing routine and rituals which still exist in nursing today may be seen as being in conflict with this changed philosophy (Kerr et al., 2011). However, a recent example of returning to routine practice is the re-introduction of routine ward rounds. Government officials and hospital administrators reintroduced these in order to promote patient safety, quality and satisfaction with nursing care (Hutchinson & Jackson, 2016).

## **2.10 Chapter conclusion**

This chapter has explored relevant literature comprising of research, professional discourse and policy in context for this study. The literature review expanded overtime in order to incorporate emerging concepts and has been presented thematically. The concepts, which emerged from analysis of this literature, are discussed as relevant to the findings. The chapter has concluded by reiterating the gap in existing literature and research, which this thesis aims to address. The following chapter discusses the conceptual framework that has informed this research.

## **Chapter 3 Developing a Conceptual Framework**

### **3.1 Introduction to chapter**

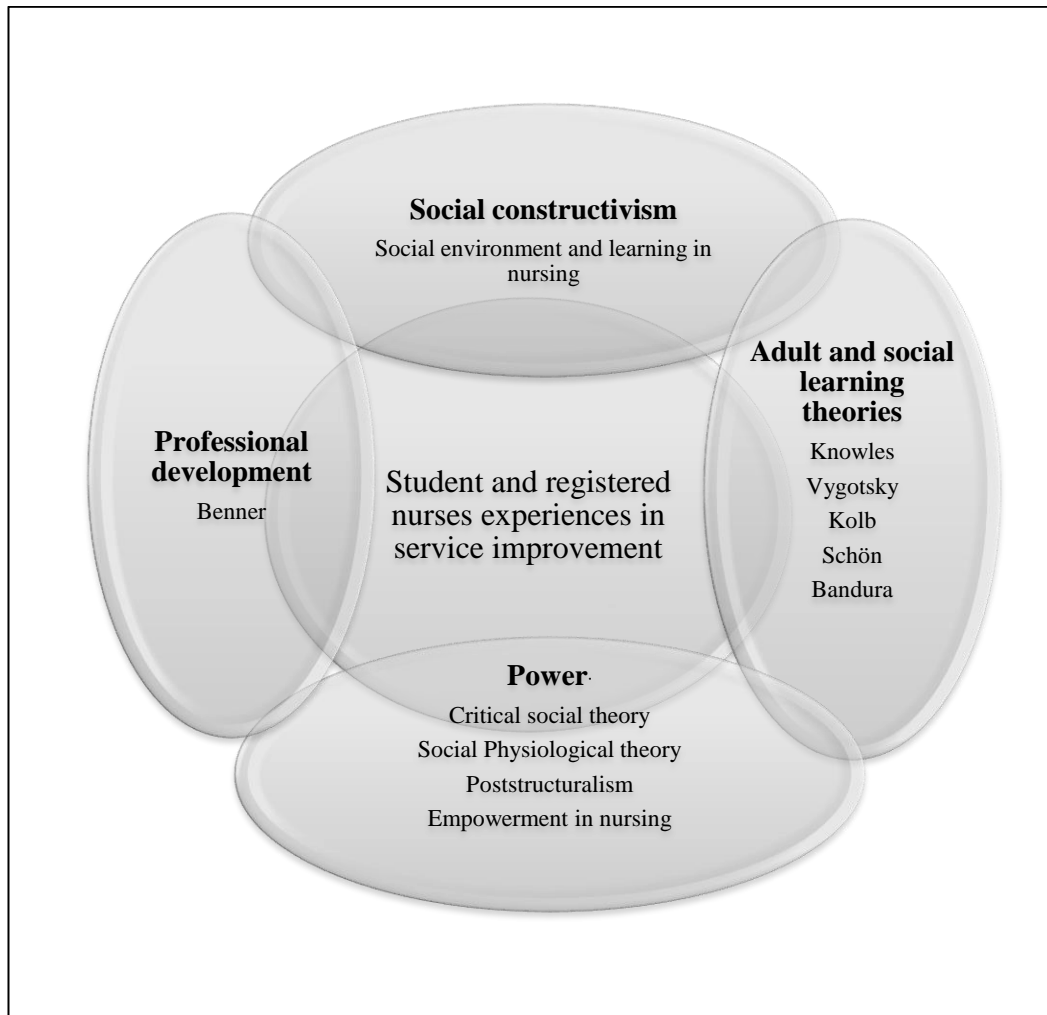
This chapter explores the conceptual framework, which informed the development of this thesis. There are several different perspectives of what function a conceptual framework plays in research (Ravitch & Riggan, 2012). A conceptual framework can be a simple visual representation of theoretical themes and concepts. Another perception sees theoretical considerations and the conceptual framework as being synonymous. A conceptual framework can illuminate relationships between key elements of the inquiry including the research paradigm, methodology, theoretical considerations and pertinent literature. However, it is important that researchers make a distinction between using existing theory, which underpins their own research, clearly identifying original or new concepts as their own. The function of the conceptual framework in this study was to highlight the relationships between existing literature and the research methodology that combined to inform analysis of findings. Social constructivism, social and adult learning theory, professional development and power are theoretical considerations that underpin analysis of findings in this thesis (Figure 4). This resulted in a new theoretical understanding of service improvement in nursing which is discussed later in this thesis.

#### ***3.1.1 Emerging concepts in the conceptual framework***

The literature review in the previous chapter illustrated different concepts important for student and registered nurses in making service improvements in nursing. The conceptual framework moves beyond these abstract concepts and provides a framework from which to challenge existing theory and inform the findings of this study. Four theoretical concepts were identified as a basis from which to explore service improvement experiences from student and newly registered nurse.

Figure 4 illustrates each concept with different key theoretical considerations applied to the research aim. Each concept will be discussed in turn:

**Figure 4 Conceptual framework**



### **3.2 Social constructivism**

Constructivism is grounded in the scientific study and observation of how people learn (Brandon & All, 2010). Constructivism is a concept which has evolved over time (Chambers, Thiekötter, & Chambers, 2013). However, within existing literature there are ambiguities between different interpretations of constructivism, where the terms social constructivism, cognitive constructivism and constructionism are often used

interchangeably (Young & Collin, 2004; Talja, Tuominen, & Savolainen, 2005; Brandon & All, 2010). Gergen (1999) cautioned there are distinctions between different interpretations of constructivism, which can cause confusion to researchers as to what concept is the foundation of their research.

This study acknowledges social constructivism as the theoretical framework underpinning this thesis. Social constructivist theory is situated within an epistemology acknowledging multiple socially constructed truths, perspectives and realities rather than a single reality (Duane & Satre, 2014). It is a sociological theory focusing on how individuals construct and apply their knowledge within social contexts and norms; acknowledging knowledge is constructed socially using language, where people process stimuli from their environment and produce adaptive behaviours based on their experiences (Driscoll, 1994; Goding & Edwards, 2002; Potter, 2003; Young & Collin, 2004; Brandon & All, 2010; Cruickshank, 2012; Chambers et al., 2013; Duane & Satre, 2014; Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014).

Social constructivism aims to understand the variety of constructions that individuals make, seeking a consensus of meaning whilst being aware of new explanations gained through experience and social interactions (Guba & Lincoln, 1989; Brandon & All, 2010). The social dimension is centre stage, where learning is a social function rather than being individual (Crotty, 2003). Social constructivism is a prerequisite for thought and social interaction and enquiry should focus on interactions, processes and social practices (Young and Collin 2004). As such, social constructivism is not necessarily a form of pedagogy but more a philosophy, where learning is a process of creating meaning from different experiences and interactions. Gergen (1999) suggested that the mind constructs reality through its relationship to the world and this mental process is significantly informed by influences received from societal conventions, history and interaction with others.

Social constructivism is helpful in educating nurses through improving critical thinking skills and encouraging the rapid adaptation to change required in evidence-based practice. Hence, it is necessary to consider the role of social constructivism in nurse education and practice (Brandon & All, 2010). Social constructivism draws attention to cultural, historical and political contexts of theory and practice and allows discourse order to uncover issues of power and ideology (Young & Collin, 2004). This view of social constructivism corresponds with the work of Foucault (1995) in relation to power (Talja et al., 2005).

### ***3.2.1 Social constructivism and nursing***

Social constructivism is relevant to nurse education and practice because students and registered nurses work in a social environment where they apply underlying principles, theory and knowledge in their clinical practice. Therefore, understanding social interactions and complexities of learning in a practice-based environment is a notion which is critical in the application of evidence-based practice in the clinical setting (Lewis, 1998; Thomas et al., 2014). The learning environment in nursing practice is socially constructed, through interactions and relationships among staff in teams and within organisations, promoting opportunities that encourage and support the building of new knowledge and understanding (Levett-Jones & Lathlean, 2008; Kala et al., 2010).

Education seeks to capitalise on learners' previous experiences; their multiple perspectives, opportunities and interactions in order to embed learning in a relevant social context (Hunter & Krantz, 2010). Nurse educators need to facilitate active learning and social interaction for nursing students as this is a crucial determinant of successful learning (Kala et al., 2010). Brandon and All (2010) suggest student nurses use previous constructs to form the foundation of their learning based on previous experiences, dialogue and interactions with colleagues and mentors.



Spouse (1998) discussed talking through or proleptic instruction, where dialogue takes place during clinical activity when the mentor and student nurse are working together. The mentor can be supportive or challenging and the student is encouraged to undertake tasks in order to reach their potential. Students learn through solving problems, inventing solutions and constructing new knowledge in the process (Brandon & All, 2010). As registered nurses, individuals continue to add to their previous learning through a variety of different experiences and construct new knowledge from social interactions using language and dialogue (Duane & Satre, 2014). This social interaction and collaborative learning can increase knowledge acquisition and the motivation to learn (Vygotsky, 1978).

### **3.3 Adult and social learning theories**

All nurses are adult learners who learn and work in a social environment and as such, adult and social theories are relevant concepts to explore in context of this study. Adult and social learning principles are closely linked to social constructivism (Brandon & All, 2010). Proponents of a social constructivist approach to learning include Knowles (1979), Vygotsky (1978), Schön (1983) and Bandura (1985). A range of themes will now be discussed in the context of this thesis. However, as there is not the scope within the thesis for an expansive discussion, only the key points of relevance for each are identified.

#### ***3.3.1 Pedagogy and Andragogy in Nurse Education***

Pedagogy considers the nature of knowledge; what and how concepts taught and how do students and teachers learn (Ironside, 2001). Pedagogy is an approach to teaching which develops knowledge in many different settings (Ironside, 2003). In nursing, different pedagogical approaches are used in teaching in order to help nurses develop their knowledge and clinical skills, both in university and clinical practice. However, there are no professional regulations outlining which approaches are best suited to professional nurse education (Mackintosh-Franklin, 2016).

Nurse education is sometimes still based on traditional, teacher-centred approaches (Ironside, 2001; Knowles, Holton, & Sawanson, 2011; Horsfall, Clearly, & Hunt, 2012). However, traditional approaches have been criticised, as they do not consider the student as an adult learner (Quinn, 2007; Knowles et al., 2011). As a result, nurse education has seen a paradigm shift toward more contemporary teaching approaches (Horsfall et al., 2016).

Andragogy has been widely adopted in nurse education as it recognises student nurses as adult learners and reflects value of the individual; which is inherent nursing practice (Allen, 2010; Horsfall et al., 2012). In nurse education, the clinical placement component of education is critical (Houghton, 2012). Andragogy is relevant to how nurses learn as it considers the nature of knowledge acquisition; accepting knowledge is not fixed, rather it socially constructed (Mackintosh-Franklin, 2016). Teaching is a collaborative process, with an emphasis on discussion and interpretation of information from a range of differing perspectives; where challenge to knowledge and assumptions involves complex decision-making (Ironside, 2006; Brandon & All, 2010). Through this process, the educator is attempting to change the students' worldview or thinking (Mackintosh-Franklin, 2016). Valuing student nurse's engagement in learning, echoes team working in clinical practice and provides conditions that foster adult learning behaviours, allowing educators in the classroom or clinical setting to facilitate and teach (Horsfall et al., 2012). This discourse helps students develop an ability to make decisions, act independently and become more confident (Elcigil & Sari, 2008). Such skills are essential in service improvement in nursing.

### ***3.3.2 Knowles' Adult Learning Theory***

Knowles' Adult Learning Theory identified how the adult learner's previous experiences build up and promote active learning (Knowles, 1979). Adult learners are self-directed; actively engaged in the learning process and have autonomy and self-direction to be able

to recognise their own learning needs (Knowles et al., 2011). Adult learners translate these needs into learning objectives, identifying and using appropriate resources in order to accomplish these needs and can evaluate the extent to which they have been accomplished (Knowles et al., 2011). They focus more on the process and relevance of learning rather than the content of curriculum and exhibit behaviours including problem solving, critical reflection, active participation and experiential learning (Knowles, Holton, & Swanson, 1998).

However, there is a lack of research which shows the principles which Knowles' (1979) espouses are effective (Norman, 2000). Knowles et al., (1998) acknowledged the principles of adult learning theory appear obvious and argues that in order for them to be successful, educators need to foster the conditions and principles in both clinical and classroom settings. Prerequisites for an effective learning environment include respect for the student as a person, recognising student autonomy and their intrinsic motivation to learn (Knowles et al., 1998). Motivation for on-going learning is important in nursing practice where nurses must engage in life-long learning as part of their professional development (Benner et al., 2010), including service improvement learning.

### ***3.3.3 Vygotsky's Zone of Proximal Development***

Vygotsky theorised that learning takes place within a Zone of Proximal Development (ZPD), where social interactions play a fundamental role in the process of cognitive development.

This type of learning is founded on social constructivism where the focus is on interactions between individuals, encouraging students to be active learners in a social and cultural context (Green, Wyllie, & Jackson, 2014). Vygotsky (1978) found that competent teachers hand down cultural values to students through dialogue and interactions, where learners understand what they can do on their own and understand when and where they need help.

Educators or peers, teach learners who, as they become accomplished, no longer need the support of the teacher. In the context of nursing, the dialogue with a more experienced mentor or colleague extends the boundaries of the learners' ZPD. Students reframe their knowledge within the practice context in order to relate one to the other (Spouse, 1998). This approach to education is theoretically appropriate for learning in social environments such as nursing. It is especially relevant to service improvement learning where action to change is the aim. However, this approach requires the teacher (in the practice setting) to have enough knowledge and time to ask the right questions and engage in dialogue with the student (Andrews & Roberts, 2003).

### ***3.3.4 Kolb's Experiential Learning Theory***

Kolb's (1984) model of experiential learning is significant in nursing education as it incorporates how humans adapt and learn through a life-long process of person-environmental interactions (Laschinger, 1987). Kolb defined experiential learning as:

*"A holistic, integrative perspective on learning that combines experience, cognition and behaviour"* (Kolb, 1984, p. 21)

Kolb (1984) suggested individuals experience three growth and development stages in their lives namely acquisition, specialisation and integration. These stages of development have relevance to this study it is longitudinal and the participants, from student to newly registered nurses work and learn within a social learning environment. The concept of life-long learning is a model which Benner et al., (2010) espouse is the basis for professional development in nursing, allowing nurses to move beyond basic education to become questioning, reflective and curious learners.

There are four phases of learning including concrete experience, reflective observation, abstract conceptualisation and active experimentation. (Kolb, 1984). Firstly, concrete experience provides the basis for the learning. New knowledge is created through

participation in concrete experiences via a learning cycle that focuses on active problem solving. Lessons are learnt through adaptability and open mindedness rather than a systematic approach to the situation or problem. With reflective observation, learning occurs through experience and by articulating why and how things occurred. Learners reflect, observe and critically examine their experiences from all perspectives. Learning is an active process where knowledge is created through interactions and environmental factors and becomes the basis for new experiences (Laschinger, 1987). Abstract conceptualization considers observations and reflections made by the learner during a reflective stage. Learners use logic and ideas as opposed to feelings to understand situations and problems. Finally, active experimentation involves the learner testing the theories to make predictions about reality and then act on those predictions (Akella, 2010). All four phases of Kolb's experiential learning theory became evident through data collected during this study as explained later in this thesis.

### ***3.3.5 Schön's Critical Reflection Theory***

Schön (1983) developed Critical Reflection Theory, which has been widely adopted in nursing (Boud & Walker, 1998; Murphy, 2005; Hatlevik, 2012). Nurses engage in reflective practice as a means to synthesise information; link concepts and develop critical thinking (Hunter and Krantz, 2010). Schön (1983) suggested theoretical knowledge taught in universities and its application in nursing practice, can be linked by academics and nurses through reflective activity (Gardner, 2012).

Reflective practice is a process through which nurses can bridge the gap between theory and practice and develop tacit knowledge (Hatlevik, 2012). This has relevance to this study as service improvement learning in nursing has both theoretical and practice components.

Schön (1983) identified reflection in and reflection on action, which can enhance learning from experience (Murphy, 2005). Reflection in action considers knowledge intrinsic in practice is understood. Schön (1983) considered this as where:

*“The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings, which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation”* (Schön, 1983, p. 68)

Reflection on action occurs later, after the experience and allows for deeper analysis of the situation. As learners reflect on, and articulate their experiences, they undergo deeper learning and develop new knowledge (Hatlevik, 1998; Murphy, 2005). Reflection-on-action occurs through dialogue with teachers, colleagues and mentors which facilitates deeper thinking of the experience; permits the asking of pertinent questions and allows development of new ideas based on the experience. Schön suggests:

*“When a practitioner makes sense of a situation he perceives to be unique, he sees it as something already present in his repertoire. To see this site as that one is not to subsume the first under a familiar category or rule. It is, rather, to see the unfamiliar, unique situation as both similar to and different from the familiar one, without at first being able to say similar or different with respect to what. The familiar situation functions as a precedent, or a metaphor, or... an exemplar for the unfamiliar one”* (Schön, 1983, p. 138)

This has relevance to this study as the participants were sharing their reflections ‘in’ service improvement learning. They were also sharing their experiences ‘on’ service improvements later as they reflected more deeply on their experiences.

Nevertheless, there are criticisms of reflection in nursing. Benner (1984) challenges Schön; suggesting reflection in action is meaningless if expert nurses have to use a formal model or rule, then their performance may deteriorate. Benner (1984) also criticises reflection on action as being pointless, as intuitive decisions are not based on rational thought; it is not possible to discuss and reflect after the event. Boud and Walker (1998) found reflection can be carried out incorrectly or be inappropriate. Inappropriate reflection may reinforce

prejudices and bad practice, leading practitioners to collude with cultural assumptions (Boud & Walker, 1998). Murphy (2005) found it can be difficult to fit reflection in action on a busy day on the ward and the value of reflection can be missed. Learners may only undergo surface learning, lacking the nuances of each unique situation (Murphy, 2005). Despite these criticisms, reflection is regarded as an essential feature in how nurses make considered decisions and evaluate effectiveness (Boud & Walker, 2008). Murphy (2005) found teaching methods that include reflective practice, help promote learning and empower the learner; this includes in service improvement learning (NHSII, 2008b).

### ***3.3.6 Bandura's Social Learning Theory***

Bandura (1971a) developed a social learning theory based on observation, imitation and modelling. Bandura explained human behaviour as a process of interactions between cognitive, behavioural and environmental influences (Bandura, 1971a). Social learning theory in nurse education focuses on the social attributes of learning which take place in a social environment, acknowledging the complexity of the environment and the individual (Bahn, 2001; Houghton, 2014). This has relevance for this study as student and newly registered nurses work in a social context with interactions and social contact with mentors, colleagues and peers.

Social learning theory has four mechanisms, self-regulation, self-efficacy, observation and reciprocal determinism, which collectively facilitate learning through observing role models who are emulated and admired (Bandura, 1971a,b; Bandura, 1985). Bandura termed this learning behaviour as 'modelling'. Several conditions are necessary for effective modelling including attentional, retention, motor reproduction and motivational processes. (Bandura, 1971a,b). Attentional processes are concerned with how individuals learn from example. Learners select characteristics from the role model that they view as relevant. With retention, role model behaviour is considered and individuals consider how they can replicate their activities. Motor reproduction involves learners giving a response

based on the modelled patterns they have observed. Finally, motivational processes are concerned with how individuals acquire, retain and possess the ability to carry out modelled behaviour. It considers the motivation to replicate behaviours based on tradition, incentives and vicarious experiences. These theoretical components of social learning theory are significant in nursing where the acquisition of knowledge and skills are based on affective, cognitive and psychomotor behaviours which students experience in order to develop both competence and confidence (Bandura, 1997b). This requires a capacity for the individual to be self-reflective and self-reactive which empowers them to develop personal values which can motivate their own improvement behaviours (Bandura, 2002). Learning service improvement behaviours are no exception. Positive reinforcement can influence the skilful execution of behaviours. In contrast, negative reinforcement can also influence the individual's performance (Bandura, 1971a, b); this will become evident in later discussion in the thesis.

Bandura (1971b) suggests that disapproval of modelled behaviours will deter individuals from carrying out inappropriate behaviours or actions if it breaches their moral principles or if it is socially unacceptable. Those meeting disapproval for their actions tend to constrain similar behaviour in others. Despite this, Koontz et al., (2010) argues that role modelling can allow student nurses to imitate behaviours observed in clinical practice that are not best practice, for example taking shortcuts or omitting steps in care (Koontz et al., 2010). If inappropriate behaviours occur without any adverse consequences then reinforcement is likely to increase its adoption (Bandura, 1971b).

### **3.4 Power: different theoretical positions and empowerment in nursing**

Power from a social constructivist perspective recognises socially constructed systems are designed to reproduce and sustain power imbalanced relationships (Gray & Thomas, 2005). Power permeates social norms and as such, social constructivism and power are intrinsically linked (Potter, 2003). Nursing occurs in a social environment, therefore, the



concept of power has implications for individual nurses and the nursing profession as a whole (Gray & Thomas, 2005; Bradbury-Jones et al., 2008)). It is important to understand power and its impact on nursing within the context of this study.

There are several different theoretical views and perspectives of power. These include critical social theory, social psychological theory and poststructuralism (Foucault, 1995; Kuokkanen & Leino-Kilpi, 2000; Daiski, 2004; Gray & Thomas, 2005; Bradbury-Jones et al., 2008).

#### ***3.4.1 Critical Social Theory***

Critical Social Theory contends that certain groups in society are subordinate to a controlling group holding prestige, power and status (Bradbury-Jones et al., 2008). Power is interpreted in terms of coercion and domination (Kuokkanen & Leino-Kilpi, 2000). This perspective arguable occurs in nursing, which is hierarchical in both structure and management (Bradbury-Jones et al., 2008; Kuokkanen & Leino-Kilpi, 2000). Nurses could be considered as an ‘oppressed group’, dominated by those deemed to be in more powerful positions (Fulton, 1997; Daiski, 2004). An example of oppression in context of this study may be student nurses dominated by registered nurses. Nurses described personal power in terms of their knowledge base and authority to make decisions (Fulton, 1997). Student nurses arguably have less knowledge and authority than that of registered nurses. However, power does not necessarily form part of a hierarchical system and is not always repressive (Kuokkanen & Leino-Kilpi, 2000). Therefore, Critical Social Theory is inadequate in capturing the complexity of the concept of power in nursing (Bradbury-Jones et al., 2008).

#### ***3.4.2 Social Psychological Theory***

Social psychological theory considers power and individual experiences of power. Empowerment as a process of personal growth and development, and the individual’s beliefs, values and perceptions are key factors (Kuokkanen & Leino-Kilpi, 2000). This

individual approach gives a social psychological perspective of power appeal within nursing (Bradbury-Jones et al., 2008). However, within nursing, social psychological theory is limited due to the complexities of healthcare where the cultural and political influences which impact nursing, may be overlooked (Bradbury-Jones et al., 2008).

### **3.4.3 Poststructuralism**

This study considers poststructuralism as an appropriate theoretical basis of power in nursing. Michael Foucault's premise that power is exercised rather than possessed, it is not fixed, rather it emanates from every force relation in society; with each interaction and is everywhere (Foucault, 1995):

*"Power is not exercised simply as an obligation or a prohibition on. Those who 'do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves. In their struggle against it, resist the grip it has on them"* (Foucault 1995, p. 27)

Poststructuralists see power as pervasive; involved in all human interactions and which changes depending on the context (Kuokkanen & Leino-Kilpi, 2000; Bradbury-Jones et al., 2008). Power is not merely a repressive force, it can also be productive through forms of knowledge and discourse (Foucault, 1980). As such, power from a poststructuralist perspective can be viewed from a bottom up and a top down approach (Foucault, 1995).

Foucault (1995) describes two fundamentals of power through disciplinary and knowledge power relationships. These fundamentals of power have relevance to this study that was longitudinal, from student to newly registered nurse. In nursing, disciplinary power is exercised through a combination of hierarchical observation, normalising judgement and examination (Bradbury-Jones et al., 2008). Hierarchical observation concerns being unobtrusively watched (Foucault, 1995). In nursing, this occurs through nurses observing the practice of others as well as being responsible for their own practice (Bradbury-Jones et al., 2008). Mentors support and observe student nurses for at least 50% of their clinical

placement (NMC 2008; NMC 2010). Hierarchical observation considers how nurses are judged and compared with particular norms, not only from a hierarchical perspective but also from peers and patients (Bradbury-Jones et al., 2008). This process combines with examinations so that observations make it possible to qualify, classify or punish (Foucault, 1995). Hierarchical observation is demonstrated through achieving competencies, completing assignments, gaining qualifications and receiving feedback during interactions with colleagues and patients (Bradbury-Jones et al., 2008).

Power and knowledge are interlinked; where there is power there is also knowledge (Kuokkanen & Leino-Kilpi, 2000):

*“Each society has its regime of truth, its ‘general politics’ of truth: That is, the types of discourse which it accepts and makes function as true... (and) the status of those who are charged with saying what counts as true” (Foucault 1980, p. 131)*

This perspective of power through knowledge is relevant in nursing as knowledge is generated through procedures and structures, which determine what can be done, and by whom (Bradbury-Jones et al., 2008). Power is associated with authoritative leadership within a hierarchical structure, where one person can limit another's freedom of action (Kuokkanen & Leino-Kilpi, 2000).

Bradbury-Jones et al., (2008) found nurses are relatively powerless in some situations whereas in other circumstances they hold more power. Research has shown that nursing is hierarchical, where there can be disrespect of nursing students and a lack of empowerment for them within this hierarchy (Fretwell, 1982; Kuokkanen & Leino-Kilpi, 2000; Bradbury-Jones et al., 2008).

#### ***3.4.4 Empowerment in Nursing***

Empowerment in nursing is inextricably linked to the concept of power (Kuokkanen & Leino-Kilpi, 2000; Bradbury-Jones et al., 2008). Bradbury-Jones et al., (2008) suggest

poststructuralism is a way that researchers can understand power and empowerment in nursing. The word empowerment stems from the Latin '*potere*' meaning:

*"A social process of recognising, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their own lives"* (Gibson, 1991, p.359)

Empowerment in nursing is complex and dynamic, where power can be given and taken away depending on the context (Kuokkanen & Leino-Kilpi, 2000; Bradbury-Jones et al., 2008). Empowerment is appealing to nursing as it is related to professional development and nurse/patient relationships, with interrelated attributes, characteristics and uses within nursing literature and practice (Gibson, 1991; Kuokkanen & Leino - Kilpi, 2000; Bradbury-Jones, Sambrook, & Irvine, 2008). However, empowerment does not occur as a result of individual experiences; rather it is a continuous social process which fosters understanding, development and building capacity so individuals are able to control and facilitate action over their own lives (Madden, 2007). Empowerment can improve self-esteem for the individual (Rodwell, 1996) and is fundamental to success and job satisfaction. Empowerment is a process where self-efficacy is associated with coping with situations and challenges (Bandura, 1997a).

Empowered nurses are confident, effective, engaged in their work and committed to high quality care (Madden, 2007). There is a clear link here to a commitment for service improvement.

Student nurses describe empowerment in terms of having and being given authority to act (Fulton, 1997). Being valued is a feature associated with a sense of empowerment (Bradbury-Jones, Sambrook, & Irvine, 2007). Nursing students described being empowered by feeling valued and 'part of the team', where they felt included, nurtured and able to make a difference (Bradbury-Jones et al., 2011). Mentors, who spent time with student nurses and supported after them in practice, resulted in positive learning

experiences and in this context, empowerment, meant student nurses were able to use their initiative and skills (Bradbury-Jones et al., 2007).

Whilst there are benefits of empowerment, there has been little research on the positive behavioural outcomes of empowerment (Daiki, 2004; Bradbury-Jones et al., 2011; Montani, Courcy, Giorgi, & Boilard, 2015). There is limited research that specifically illustrates empowerment through the concept of disempowerment (Bradbury-Jones et al., 2011). Fretwell (1982) found highly structured wards with rigid task allocation and strict hierarchical systems were unlikely to be conducive to learning and empowering student nurses. A lack of respect and support were contributing factors in disempowering student nurses and relationship difficulties contributed to occupational burnout and stress (Laschinger & Sabiston, 2000; Daiki, 2004). Bradbury-Jones et al., (2011) found student nurses felt disempowered depending on the context in which they are working; reporting feeling excluded, being treated insensitively and powerless to make a difference. Bandura (1995) found feelings of powerlessness can create psychological difficulties which are more incapacitating than external barriers. Conversely, learning environments that value the learner, respect students and see them as an important member of the team, promote feelings of empowerment (Bradbury-Jones et al., 2007; Bradbury-Jones et al., 2011).

Nurse educators and mentors need to promote and facilitate empowerment in nursing students (Bahn, 2001). It is crucial that student nurses feel empowered so that, despite challenges of learning new skills and knowledge in clinical practice, they feel they are able to analyse clinical practice, evaluate their effectiveness and be active in developing their own practice (Bahn, 2001). Registered nurses experienced high levels of empowerment when ward managers used leadership behaviours that cultivated perceptions of autonomy, confidence and meaningfulness (Madden, 2007). Registered nurses who feel empowered describe having personal integrity, which is demonstrated through courage, tenacity and self-esteem (Kuokkanen & Leino-Kilpi, 2000). These characteristics are fundamental in

nursing practice and integral to the 6C's of nursing which include care; compassion, competence, communication, courage and commitment (Hardacre, 2014). If nurses are to make service improvements in nursing practice, it is important to foster a culture in nursing where nurses feel empowered (Shafer & Aziz, 2013). Ward managers must be willing to shift from traditional, managerial power structures and empower staff through support and their influence, which is needed for successful service improvement work (Shafer & Aziz, 2013).

### **3.5 Professional development**

Professional development starts during education and continues throughout an individual's working life (Pennbrant et al., 2013). Professional development considers how individuals learn and develop within a social environment and through interactions with colleagues. As learners engage educational programmes and practice, they become members of the social community which they are going to enter as professionals (Abrandt Dahlgren, Hult, Dahlgren, Hård af Segerstad, & Johansson, 2006). Professional development occurs as individuals learn their profession's socially constructed norms, values and beliefs. This aligns to a social constructivist perspective of learning, where a nursing culture that incorporates and values professional development is congruent with nursing practice (Coventry et al., 2015).

Professional development in nursing begins with undergraduate study through theoretical foundations, and continues during ongoing education and practice for registered nurses working in clinical practice (Davis et al., 2014; Coventry et al., 2015). Francis (2013) highlighted the need for ongoing professional development in nursing. Professional development is a compulsory aspect of nurse registration and revalidation (NMC, 2015; Health Education England, 2015). This has relevance for this study, as nurses must develop their knowledge and skills in service improvement in order to be effective (Shafer & Aziz, 2013).

### **3.5.1 Benner's Novice to Expert**

The final theory of relevance to this study is Patricia Benner's (1982) 'From Novice to Expert', which has been widely adopted within nursing as a means of understanding how nurses professionally transform. Benner's (1982) theory evolved from work by Dreyfus and Dreyfus (1980) which focussed on artificial intelligence and skills acquisition. Benner applied this to nursing to understand and describe the different developmental stages nurses' progress through during their professional careers. Benner described a trajectory through which nurses develop from novice, advanced beginner, competent, proficient and expert (Benner, 1984). Benner's (1984) theory is closely aligned to social learning theory, in that skills that can be effectively communicated by example are seen as being extremely appropriate to nursing (English, 1993).

Benner (1984) found novice nurses new to the environment have little experience in situations where they are expected to perform. In order to function in this environment, novice nurses use rules to inform their practice. However, Benner (1984) argues:

*"Following rules, works against successful performance because rules cannot tell them the most relevant tasks to perform in an actual situation" (Benner 1984, p. 21)*

Benner (1982) described how nurses become advanced beginners when they have gained enough real life experience and can demonstrate acceptable performances. As such, learners work in their ZPD, where they need to be taught by others until they can carry out task on their own (Vygotsky, 1978). When nurses become competent, they become mindful of aims and goals in a wider context and see themselves contributing to these wider objectives. Once nurses become proficient, they are more experienced and have a wide view of a situation.

Benner (1982) describes the acquisition of knowledge and skills for expert practitioners, suggesting this is gained through both experiential and theoretical knowledge:

*“Transactions count as experience only when the person actively refines pre-conceived notions and expectations. This negative view of experience has positive outcomes. Experience is gained when theoretical knowledge is refined, challenged, or disconfirmed by actual clinical evidence that enhances or runs counter to the theoretical understanding”* (Benner 1984, p. 294)

However, Higham & Arrowsmith (2013) question Benner’s (1984) emphasis on the expert practitioner and its application in pre-registration nursing. Benner (1984) argues that as nurses advance in experience they become more proficient in the clinical environment. This incremental progression is dependent on the depth and range of clinical experience and this correlates strongly with the length of time spent nursing (English, 1993). Therefore, Benner’s (1982) novice to expert model is congruent to the professional development of nurses from pre-registration to post-registration practice that is the focus of this study.

### **3.6 Chapter conclusion**

This chapter has explored the different dimensions of the conceptual framework that have informed the analysis of findings in this study. This research aimed to explore the lived experiences of student and newly registered nurses in service improvement in nursing.

The conceptual framework aligns with the research aims and questions and accepts the philosophical position of this study. My research acknowledged from the outset that student nurses and registered nurses learn in a social environment where the concepts of power and empowerment are factors that influence nursing. Social and adult learning theories inevitably affect how nurses learn as adults. Through transition from student nurse to newly registered nurses, nurses undergo a process of professional development. The four theoretical concepts of social constructivism, social and adult learning theories theory,



power and empowerment and professional development were combined to form a lens through which the findings of this study were analysed.

The following chapter discusses the research methodology chosen, which aligns to my conceptual framework in order to address the research questions.

## **Chapter 4 Research Methodology**

### **4.1 Introduction to chapter**

This chapter explores the research methodology chosen for this study and sets out my interpretivist ontological and epistemological position. This is then explicitly linked to social constructivism as the theoretical framework informing this thesis. Finally, different approaches to phenomenology are explored in order to justify choosing hermeneutic phenomenology the research design for this study.

#### ***4.1.1 Research background***

In Chapter 2, the literature review has highlighted complex and interrelated factors influencing student and registered nurses' experiences of service improvements in nursing. The aim of this research was to provide an understanding of these lived experiences and as such, a number of specific research objectives were identified:

- To investigate the lived experiences of nursing students in service improvement after they had completed a module on service improvement in university and clinical practice.
- To identify and explore factors, which influence nursing student's learning and experiences in service improvement practice.
- To understand how student nurses, adapt to being newly registered nurses in making service improvement in nursing practice.
- To identify strategies and behaviours which student and newly registered nurses utilise in order to make service improvements in nursing practice.
- Develop a new model of understanding how nurses make service improvements in nursing practice.

In order to meet the aim of this study the following research questions were established:

1. *What are student nurse's experiences of service improvement in education and its application in clinical practice?*
2. *What are registered nurse's experiences of service improvement in clinical practice?*

With the intention of answering the research questions, it was necessary to position my research within an appropriate research paradigm that would allow the participants to share their experiences of service improvement in nursing.

#### ***4.1.2 My ontological position; using an interpretivist paradigm and social constructivism***

This research resides in a qualitative or interpretivist paradigm. The research paradigm influencing this research was identified during the initial stage of the research process. Arguably without this initial stage, there is no justification of subsequent decisions regarding research methodology, research methods or design (MacKenzie & Knipe, 2006).

Interpretivist research is underpinned by different levels of understanding which provide a framework for the research methodology (Proctor, 1998). This framework includes ontology, epistemology and methodology (Denzin & Lincoln, 2000).

Ontology refers to a theory of existence and is concerned with the nature of reality and human beings (Lee, 2012). There are ontological differences between positivist and interpretivist research paradigms. However, regardless of which approach is utilised, the research paradigm is a:

*“Basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1994, p. 105)*

Quantitative research is also known as empiricism or positivism (Carr 1994) where researchers use statistical procedures in order to predict, explore and describe phenomena

(Onwuegbuzie & Leech, 2005). Positivism is an objective approach to research that uses formal, systematic means to measure phenomena and produce findings (Carr, 1994; Onwuegbuzie & Leech, 2005). Positivist researchers believe reality can be measured reliably and validly through scientific principles and is concerned with finding truth and meaning; considered to exist out-with of the knower, residing in the objects themselves (Crotty, 1998).

Historically, nursing as part of the wider medical profession, has arguably embraced a positivist view of the world (Warelow, 2013). However, Polit and Beck (2010) argue nursing research can benefit from using both positivist and interpretivist paradigms as both approaches have positive features (Mahoney & Goertz, 2006). Research in nursing has seen a shift towards non-positivist philosophies which has changed the theoretical focus away from causation to a more interpretive, unscientific standpoint; which has provided the basis of qualitative research in nursing (Warelow, 2013).

Qualitative research or interpretism rejects the positivist stance of using scientific methods to study social observations. Interpretivist research develops theory inductively as there is no intention of quantifying findings. Interpretivist researchers believe there are multiple constructed realities that contain different meanings for each individual. To the interpretive researcher, reality is not rigid; it exists within its own composition and is influenced by its context (Crossman, 2003). Crotty (1998) states:

*“All knowledge and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed within an essentially social context”* (Crotty 1998, p. 42)

Annells (1996a) suggests the philosophical basis of research should be compatible with the ontological position of the researcher.

The researcher's personal and professional experiences help shape their worldviews and this often influences their research approaches (Cresswell, 2009). I am in agreement with this perspective. I have personal and professional values and beliefs that have shaped me as a nurse and educator. My nursing practice, teaching and experiences of service improvements in nursing have all influenced my ontological position.

My ontological stance is based on my belief that there are multiple constructed realities. This belief is founded on my experiences as a nurse and educator, where I have learnt and practiced within a social environment and have been influenced by interactions with students, colleagues and patients. Nurses learn and work in an environment that is socially constructed (Levett-Jones & Lathlean, 2008; Kala et al., 2010). This research has accepted a social constructivist view of learning as discussed in Chapter 3. Therefore, it was important that the research methodology chosen for this study aligned to social constructivism. Social constructivism positions the individual at the centre of the experience and the focus is on the individuals' learning which occurs through their interactions within a particular social context (Thomas et al., 2014). Researchers who use a social constructivist framework believe that individuals give meaning to reality, events and phenomena through ongoing and complex processes of social interaction (Denzin & Lincoln, 2005). It is not possible to separate facts and values as understanding is inexorably influenced in terms of the individual and the event (Elliott & Lukes, 2008).

#### ***4.1.3 Epistemology and interpretative phenomenology***

Epistemology in its most simple terms is the theory of knowledge (Crotty 1998). Epistemology asks the question:

*“What is the relationship between the inquirer and the known?”* (Denzin and Lincoln 2000, p. 157)

My philosophical position reflects my belief that I am an integral part of the research process, alongside the participants. Interpretivist researchers acknowledge that they bring their own unique interpretations of the world, or construction of the situation, to their research and need to be open to the attitudes and values of the participants; suspending any prior cultural assumptions (Elliott & Lukes, 2008). Findings emerge between the researcher and the participants as part of their interactions and interpretation of data is reliant on the researcher's ability to interpret the phenomena (Onwuegbuzie and Leech, 2005; Creswell, 2007; Elliott & Lukes, 2008). Meanings are constructed by humans in unique ways, dependant on personal frames of reference and their individual context, as they interact with the world they are interpreting (Crotty 1998). Interactions are ongoing through an interpretative or hermeneutic process of data analysis when the investigator seeks convergent viewpoints and explanations for any discrepancies (Appleton & King, 2002). Through this process, insight into the lived experiences allows findings to emerge. Lincoln and Guba (1985) suggest researchers take advantage of this interactive process and consider discourse as fundamental to them discovering differing views of reality that may exist.

This study sought to explore the experiences of service improvement in nursing for participants. Phenomenology was appropriate as a research methodology as it seeks to understand particular phenomenon as it is lived by participants (Polit & Hungler, 1999; Robson, 2005). Heidegger's (1962) philosophical approach to phenomenology was interpretative, where understanding is an integral part of human experience and cannot exist outside of one's culture or history. Crotty (1998) suggests that truth and meaning of the phenomena are not seen in isolation from the knower, rather, values are important to knowledge creation as researchers propose facts are 'value' and 'theory' laden (Guba & Lincoln, 1989). Interpretivist researchers see themselves and the participant as dependent on each other and they utilise this relationship in order to understand the phenomena (Onwuegbuzie and Leech, 2005). Their personal reality, experiences, beliefs, values, culture and understanding of the world will inevitably impact on how the research is

interpreted and where the participant's data creates a shared understanding (Onwuegbuzie and Leech, 2005). Interpretation occurs with an understanding that the researcher is part of the historical, social and political world (Heidegger, 1962). Acknowledgement of researcher and participant relationships fits with interpretive phenomenology as the chosen methodology of my research. The relationship between the researcher and participants is not detached, rather the findings are a collective between the researcher and participants as throughout data collection they are constantly influencing each other (Guba & Lincoln, 1989):

*"It is precisely their interaction that creates the data which will emerge from the inquiry"* (Guba and Lincoln 1989, p. 88)

However, a criticism of interpretivist research is that the researcher is too close to the participants (Parahoo, 1997). Nevertheless, this closeness is also a strength, as the shared exploration of time, space and personal experience is the value of interpretivist research (Parahoo, 1997). This perspective is congruent with Heidegger's (1962) approach to interpretive phenomenology and is consistent with my own worldview. My experiences and understanding have given me insight in context of service improvement in nursing and this would inevitably influence my interpretation of the findings.

## **4.2 Research methodology**

My ontological and epistemological positions were the basis for selecting hermeneutic phenomenology as my chosen methodology. The next part of the chapter discusses phenomenology through its various traditions; from descriptive to interpretivist paradigms.

### ***4.2.1 Phenomenology in nursing research***

Phenomenology is a methodological approach, which has been utilised increasingly within nursing research (Crotty, 1996; Geanellos, 1998; Mackey, 2004; Lopez and Willis 2004;

Salmon, 2012). Nurse researchers have used phenomenology as a way to develop knowledge that is culturally relevant and consider the depth and diversity that exists in nursing environments and clinical practice (Annells, 1999; Lopez and Willis 2004; Salmon, 2012). Phenomenology is pertinent to nursing as its orientation is to the lived experience and considers relationships that nurses have with patients and each other. Phenomenology is the:

*“Study of phenomena...its tends to be human experiences-experiential phenomena”* (Annells 1999, p.6)

Exploring these experiences, relationships, beliefs, practices and cultures, with the intent to understand the meaning of the person’s experiences, all hold an appeal within nursing research (Van der Zalm & Bergum, 2000).

Early research in nursing was dominated by a descriptive approach to phenomenology (McNamara, 2005). However, many nurse researchers now utilise an interpretive approach to phenomenology (Benner 1994; Annells, 1996; Corben, 1999; McNamara, 2005). Nevertheless, Crotty (1996) argues there is often confusion between the phenomenological philosophy and research methodology used in nursing research. Crotty (1996) found some nurse researchers used phenomenological methodology and research methods that are incongruent with each other and their research aims. Crotty (1996, p.76) suggested that nurses simply ‘dress’ up their phenomenology in ‘Heideggerian livery’ rather than applying a genuine hermeneutic approach to their research.

Nurse researchers can alleviate concerns regarding their phenomenological methodology by being explicit and clear about the process and rationale taken in selecting their chosen philosophical and methodological approach. Benner (1994, p.258) argues that Crotty’s (1996) rejection of nurse phenomenologists is tied up in a ‘familiar pattern of maelstrom thinking’ and it lacks objectivity. Draucker (1999) contends that nurse researchers can



produce new descriptions which allow flexible and creative presentation of their findings, yet remain within a sound research framework. It is crucial that the phenomenological approach sits within an appropriate research design that is congruent with the research aim, objectives and questions. Therefore, understanding of the philosophy and evolution of phenomenology is required in order to justify the most appropriate phenomenological approach chosen for this study. It is crucial that the phenomenological approach sits within an appropriate research design and be congruent with the research questions.

#### ***4.2.2 Phenomenology***

The focus of phenomenology is to understand particular phenomenon as it is lived by participants (Polit & Hungler, 1999; Robson, 2005). The origins of phenomenology are located within philosophy and psychology and it is a methodology that has evolved and developed over time (Miller, 2003). Phenomenology is a complex research methodology which is described as both a philosophy (Dowling, 2007) and a research methodology (Crotty, 1996). However, a criticism of phenomenology is that the complexity of approaches may cause researchers to be confused and that methods, data analysis and therefore the findings of research, are often questioned (Crotty 1996).

There are many different philosophies and approaches that can be adopted within phenomenology. Philosophers and researchers including Husserl (1962) Heidegger (1962) and Gadamer (1979) have all contributed to the emerging philosophy and developing methodology of phenomenology.

#### ***4.2.3 Husserl: A descriptive tradition***

Edmund Husserl was a German mathematician and philosopher, who is generally attributed as the founder of phenomenology. Husserl aimed to develop a scientific method for finding the essential structures of consciousness (Priest, 2004). Husserl's philosophical aim was to

reveal knowledge that transcended human experience (Mackey, 2004). Husserl believed that conscious awareness was a certainty for humans and therefore was the starting point of knowledge building (Draucker, 1999).

Husserl's approach to phenomenology is descriptive, with an epistemological stance which asserts that knowledge is based on the experience of participants with no reference to analysis beyond phenomenological reduction (Draucker, 1999; Mackey, 2004). Husserl used a form bracketing which he termed *epoche* in order to arrive at the 'essence' of the phenomena (Annells, 1999). For Husserl, *epoche* was the deliberate suspension of beliefs and presuppositions in order to see the experience for itself (Corben, 1999; Priest, 2004).

Researchers using Husserlian phenomenology are required to bracket or suspend any preconceptions, experiences or social facts that they may have (Annells, 1999). Husserl argues that researchers need to suspend their beliefs and presuppositions in order to see the experience for itself (Priest, 2004). Husserl believed bracketing allowed researchers to arrive at the essence of the phenomena which enhances the reliability of their research (Annells, 1999) as bracketing frees them from prejudices, allowing them to be detached observers (Blaikie, 1993).

#### ***4.2.4 Heidegger: An interpretative tradition***

Martin Heidegger was a philosopher who was heavily influenced by Husserl; indeed, Heidegger worked with Husserl when he was Chair of Philosophy in Freiburg.

However, Heidegger changed his philosophical position; a stance he termed '*die Kehre*' or 'the turn' and later became a critic of Husserl. Heidegger accepted that there were other ways to understand phenomena which went beyond the descriptive analysis that Husserl believed.

Heidegger (1962) in 'Time and Being' described phenomenology as a way to interpret lived time and engagement with the world (Heidegger, 1962). Heidegger's core philosophical

position in phenomenology was a desire to explore the meaning of experience for humans (Heidegger, 1962). Heidegger's main concern was ontological, with the objective being to understand the phenomenon as it is described (Smith et al., 2009). Heidegger believed in duality; in how things appear, including visible and hidden meanings. Thus, Heidegger was more concerned with ontological findings and understanding of 'being itself' or '*dasein*' (Mackey, 2005). *Dasein* can be described by ordinary pre-theoretical understanding of being and can be considered simply, as our everydayness (Draucker, 1999). *Dasein* encompasses how human existence and human beings are interlinked through a layered and complex care structure that considers 'concernful involvement' (Wilson 2014, p.4). Concernful involvement does not necessarily describe conscious acts, rather the quality of the human condition where humans are unable to disengage from the world of our concerns, even when claiming indifference (Wilson, 2014). Heidegger believed that it is not possible to bracket our previous experiences and that humans will interpret the world based on these experiences and understanding. In essence, we are intrinsically linked to our world even if we try to disengage from it. In line with Heidegger (1962), my own world view is that it is not possible to suspend my previous experiences, beliefs and practices of nursing and service improvement; I am integral to the study alongside the participants.

Heidegger considered four philosophical concepts, time, being, fore-structures and space. Heidegger argues that it is through exploring these four concepts that we can interpret and understand our experiences (Geanellos, 1998). For Heidegger 'time' considers how we exist in time. 'Being-in-the-world' is concerned with how we are active in the world. 'Fore-structures' considers our feelings about our world and 'space' is where we see our place in the world. These philosophical concepts are linked closely to my research aim and are relevant to how student and registered nurses learn and work in clinical practice. Heidegger believed understanding was an integral part of human experience and could not exist outside of one's culture or history.

Therefore, we interpret our situation in the world based on our experiences. Heidegger termed this ‘*verstehen*’, that is making sense and capacity for action. This concerns our ability to do things, where actions bring about something and compel us forward into new possibilities (Heidegger, 1962). The process of understanding is through the working-out of possibilities and projected in understanding.

Heidegger (1962) suggested:

*“Interpretation is never a presuppositionless apprehending of something presented to us (rather), interpretation will be founded especially upon fore-having, fore-sighting and fore-conception”* (Heidegger 1962, p.123)

Heidegger’s interpretive approach to phenomenology is based on experiences, which should be examined in context and on their own terms. It focuses on the interpretation of the experience of others and on empathetic understanding, it is the art of interpreting hidden meaning (Smith, Flowers, & Larkin, 2009). Heidegger (1962) suggested it was impossible for researchers to set aside previous beliefs, values and understanding. He believed the researchers must have understanding of their own fore-having, fore-sight and fore-conception in order to understand and interpret the meaning of a phenomenon (Converse, 2012). Heidegger went as far as to consider the actuality of any description without interpretation to be impossible (Koch, 1996; Flowers et al., 2009). Interpretation considers the researcher as an integral part of the social, historical and political world (Converse, 2012).

Researchers who utilise interpretive phenomenology acknowledge they can only interpret something based on their own beliefs; experiences and preconceptions, which are, legitimate as part of the research process and should not be omitted (Lowes and Prowse, 2001). The researcher and participants cannot separate themselves from the environment, experiences and culture in which they live and work in.

Interpretation occurs with an understanding that the researcher is part of the historical, social and political world (Heidegger, 1962). It is a difficult process to try to eliminate one's own concepts and experiences in interpretation (Cresswell, 2009; Charalambous, 2008). Heidegger (1962) believed pre-suppositions could not be suspended or bracketed because they constitute the possibility of meaning (Draucker, 1999). In recognising and acknowledging previous preconceptions and social facts, researchers can engage in the research process and bring their own experiences and interpretations to their research (Charalambous, 2008). This position is congruent with my own philosophical belief that it is not possible to suspend my personal values, beliefs and experiences of service improvement in nursing.

The focus of this thesis is congruent with Heidegger's interpretive view of phenomenology, as the aim was to seek meaning of a phenomenon with the purpose of understanding the human experience (Crist and Tanner, 2003). This study acknowledged that all human existence is shaped by and cannot be disassociated from experiences, culture and history. The researcher is integral to the interpretation of the phenomena (Koch, 1995). For my study, the participants all had experiences of service improvement within a nursing context. An awareness of the educational, cultural, social and environmental factors, which influence how nurses learn and practice, was a crucial feature in understanding the participant's perspective (Ajjawi & Higgs, 2007). It was through recognising and acknowledging these experiences that I was able to engage in the research process (Charalambous, 2008) and together with the participants, create a construction of their lived experiences (Koch, 1999). My own belief was that my experiences in service improvement as both a nurse and academic actually benefited this research in that I had a greater understanding through contextual and personal experiences.

However due to my knowledge and experiences of service improvement in nursing, there was a potential for a skewed focus within the research. Geanellos (1998) suggests that in

order to minimise this risk, researchers using hermeneutic phenomenology need to be able to demonstrate the working out of their fore-structures through their own experiences and presuppositions. Flood (2010) suggests that the researcher can become aware of their preconceptions through the process of reflexivity. Being reflexive can support a balanced approach (Dowling, 2006) to the interpretation and analysis of findings. This research was set within an interpretivist paradigm, using hermeneutic phenomenology as the research methodology. Reflexivity is not congruent with descriptive phenomenology (Sloan & Bowe, 2014). However reflexivity plays an important role in interpretive research including hermeneutic phenomenology (Dowling, 2006; Sloan & Bowe, 2014) which acknowledges preconceptions of the researcher cannot be removed (Converse, 2012). As such, reflexivity is an important feature of this research:

*“Reflexivity refers to deliberate awareness involving both a contemplative stance (state of mind) and intentional activity aimed at recognising differentness and generating knowledge (active engagement)” (Ben-Ari & Enosh 2016, p 578)*

Dowling (2006) describes two types of reflexivity, namely personal and epistemological reflexivity. Personal reflexivity refers to self-awareness and the influence of the researcher’s individual identity, biography and interests on the research. Personal reflexivity is similar to simple reflection; however, it considers the possibility that researchers can influence their research (Tomkins & Eatough, 2010). In essence, the ontological position of the researcher influences analysis of the findings.

Reflexivity compares to the hermeneutic circle in that researchers can engage reflexively with the concepts and emotional information stored in a memory or in the moment experiences (Dowling 2006). The researcher can reflect on their previous experiences in order to support data analysis and the interpretation of findings. This process of reflexivity is more active than mere reflection (Finlay, 2002), requiring ongoing self-critique and self-

appraising of how the research may have been influenced by the researcher (Koch & Harrington, 1998).

Epistemological reflexivity corresponds with the philosophical position of hermeneutics. It recognises the personal involvement of the researcher during the research process and the interpretation which is inextricably linked to the researchers own experiences of being in the world (Dowling, 2006). Epistemological reflexivity recognises the researcher's own views and experiences as the researcher and it is being cognisant of how these may affect the research process and the participants (McCabe & Holmes, 2009). Ben-Ari & Enosh (2016) discuss this ontological and epistemological interaction as the underlying premise of social constructivism. As such, reflexivity is not a solitary practice of introspection, rather it involves discussion with others as a means to facilitate discourse and reflection (Lewis, 2000). For transparency, a reflexive summary of my thought processes and development throughout this research is presented in Chapter 8.

### **4.3 Hermeneutic phenomenology**

A core component of interpretive phenomenology is the concept of hermeneutics. The word hermeneutic is derived from *'The Messenger'* and the Greek God Hermes, who interpreted and translated messages from Zeus to human beings (Gadamer, 1979). Early hermeneutics focussed on understanding biblical texts of which there are two main understandings both grammatical and linguistic. Grammatical understanding relates to how language was written and used at a particular time. Linguistic meaning considers the reader who can identify with the writer in terms of the assumptions and interpretations that are made (Blaikie, 1993). Through the interpretation of texts, the researcher is able to develop an understanding of the phenomenon. Hermeneutic literally means 'making the obscure plain' (Blaikie, 1993).

Hans Georg Gadamer (1979) supported Heidegger's (1962) interpretive approach to phenomenology and was central in the development of hermeneutic phenomenology. Gadamer (1979) was concerned in not only hearing the words, but also in revealing the meanings behind them. Gadamer's core philosophical stance was that:

*"Understanding and interpretation are indissoluble bound up with each other and definitive interpretation is not possible as interpretation is always on the way"* (Gadamer 1979, p.300).

Gadamer (1979) argued the interpretation of data reconstructs history through the relationship between the text, the reader and the context in which they sit. The pre-suppositions the researcher brings to the research are not suspended, rather they are examined within the process. This process involves the researcher as well (Koch, 1996; Robson, 2005). Koch suggests that:

*"Data generated by the participant is fused with the experience of the researcher and placed in context"* (Koch 1996, p.176)

Gadamer (1979) inspired an interpretive methodology which enables the uncovering of meaning and understanding between texts and the researcher (Converse, 2012). Nevertheless, whilst there is recognition that interpretation of phenomenological research is the interpretation of one researcher, there is always potential for other interpretations, which may be deeper, richer or complement the research (van Manen, 1990; Ajjawi & Higgs, 2007).

Hermeneutic phenomenology can be used to clarify phenomena in the fields of pedagogy, psychology and nursing in a practical way (Sloan & Bowe, 2014). Choosing hermeneutic phenomenology for this study was based on the philosophical assumptions that underpin the research aim and questions. The aim was to understand the experiences of student and newly registered nurses in service improvement in nursing. Through using hermeneutic



phenomenology, it was possible to explore the participant's experiences using their own words and interpreting this in consideration of my own understanding.

#### **4.4 The Hermeneutic circle**

The hermeneutic circle is an ongoing, circular process where researchers and participants interpret phenomena as part of an iterative process. Heidegger (1962) suggests that:

*“In the [hermeneutic] circle, is hidden a positive possibility of the most primordial kind of knowing”* (Heidegger 1962, p. 153)

The circle starts with data collection and continues until the findings are presented, helping researchers interpret and re-experience conversations through using the text as basic data (Blaikie, 1993; van Manen, 1997). In this study, the hermeneutic circle facilitated interpretation of meanings conveyed by participants by using the participant's interview transcriptions as the source of data. Transcripts or texts are interpreted in order to obtain a valid and common understanding of their meaning (Kvale, 2011). Hermeneutic interpretation adds an interpretive element to explain meanings and assumptions in the findings that participants themselves may have difficulty in articulating (Crotty, 1998). The hermeneutic circle facilitates the relationship between the researcher and participants and helps interpretation of findings (Smith et al., 2009). The use of the hermeneutic circle in this study is discussed in the following chapter.

#### **4.5 Chapter conclusion**

This chapter has explored hermeneutic phenomenology as the methodology chosen for this study. This study is positioned within an interpretivist paradigm. Different approaches to phenomenology have been discussed and there is justification of choosing hermeneutic phenomenology as an appropriate methodological approach for this study. Hermeneutic

phenomenology is congruent with my ontological position and the research aim and questions. The following chapter discusses the research process undertaken in this study.

## **Chapter 5 Research methods**

### **5.1 Introduction to chapter**

This chapter explores the research process and methods adopted in order to address the research questions of this study. There are discussions on the sampling strategy, data collection, data analysis and ethical considerations in relation to this study. The sampling strategy used to select the participants is explained and justified. Semi-structured interviews are rationalised and discussed as an appropriate means of collecting data for this study. I explore the approach to data analysis taken which is congruent with hermeneutic phenomenology. The activities undertaken during data analysis are identified and explained. Appropriate ethical considerations are demonstrated including University and the NHS Trust permissions, participant consent and confidentiality. Finally, trustworthiness, rigor and credibility are discussed as quality measures appropriate for this study.

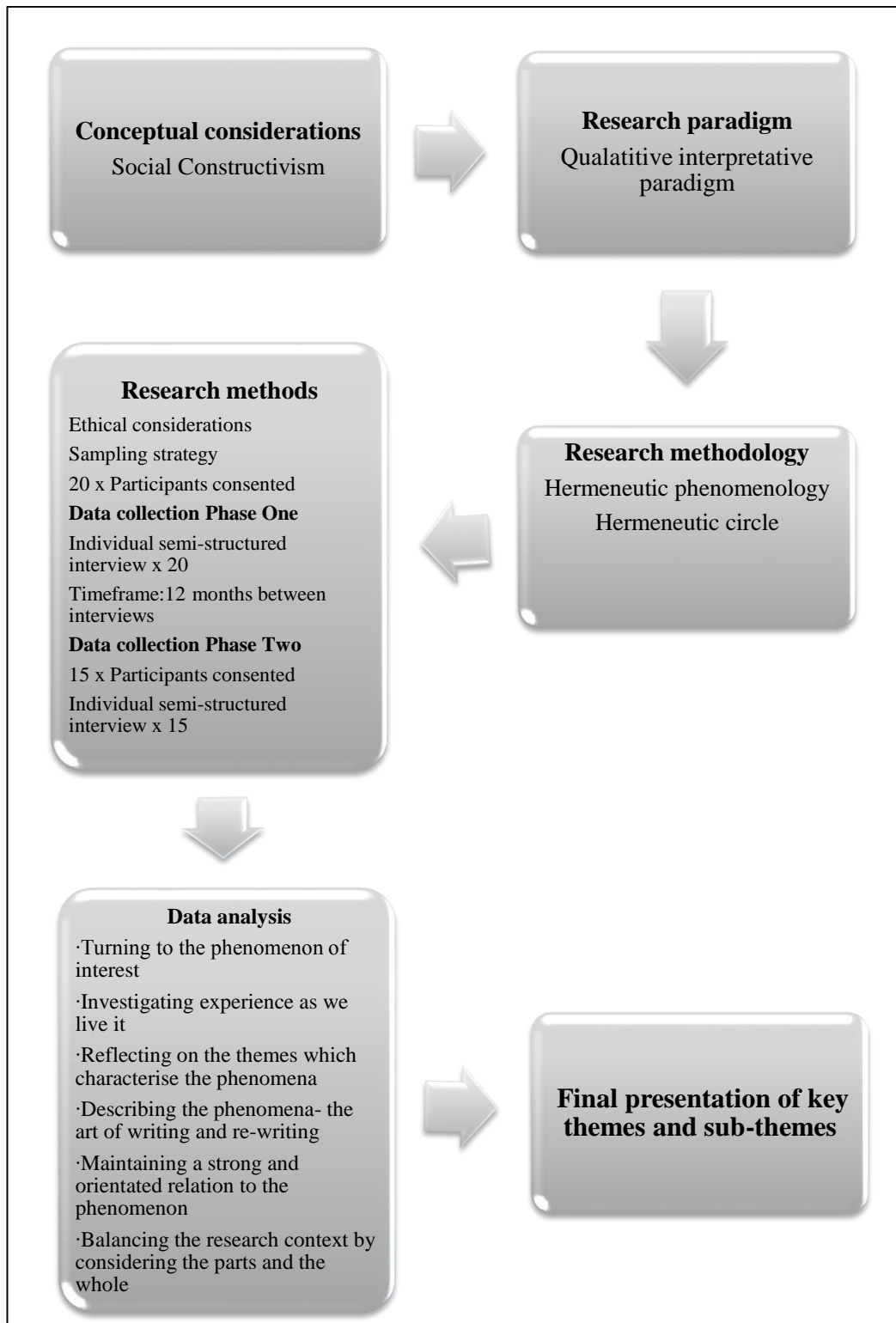
### **5.2 Research Process**

Research is a systematic investigation or inquiry where data is collected, analysed and interpreted in order to understand, predict or control an educational or psychological phenomenon (Mertens, 2005):

*“The exact nature of the definition of research is influenced by the researcher’s theoretical framework with theory being used to establish relationships between or among constructs that describe or explain phenomenon” (Mertens 2005, p.2)*

Demonstrating the process of this research, through a systematic and explicit audit trail, helps promote the trustworthiness of this work (Koch, 1996). Figure 5 provides an illustration of the of the research process undertaken during this study:

**Figure 5 Research process**



### **5.3 Sampling strategy**

In order to identify participants for this research it was necessary to develop a sampling strategy. A sampling strategy ensures there is a deliberate selection of the participants involved in the research; participants are chosen because they have specific features or characteristics (Cresswell, 2009).

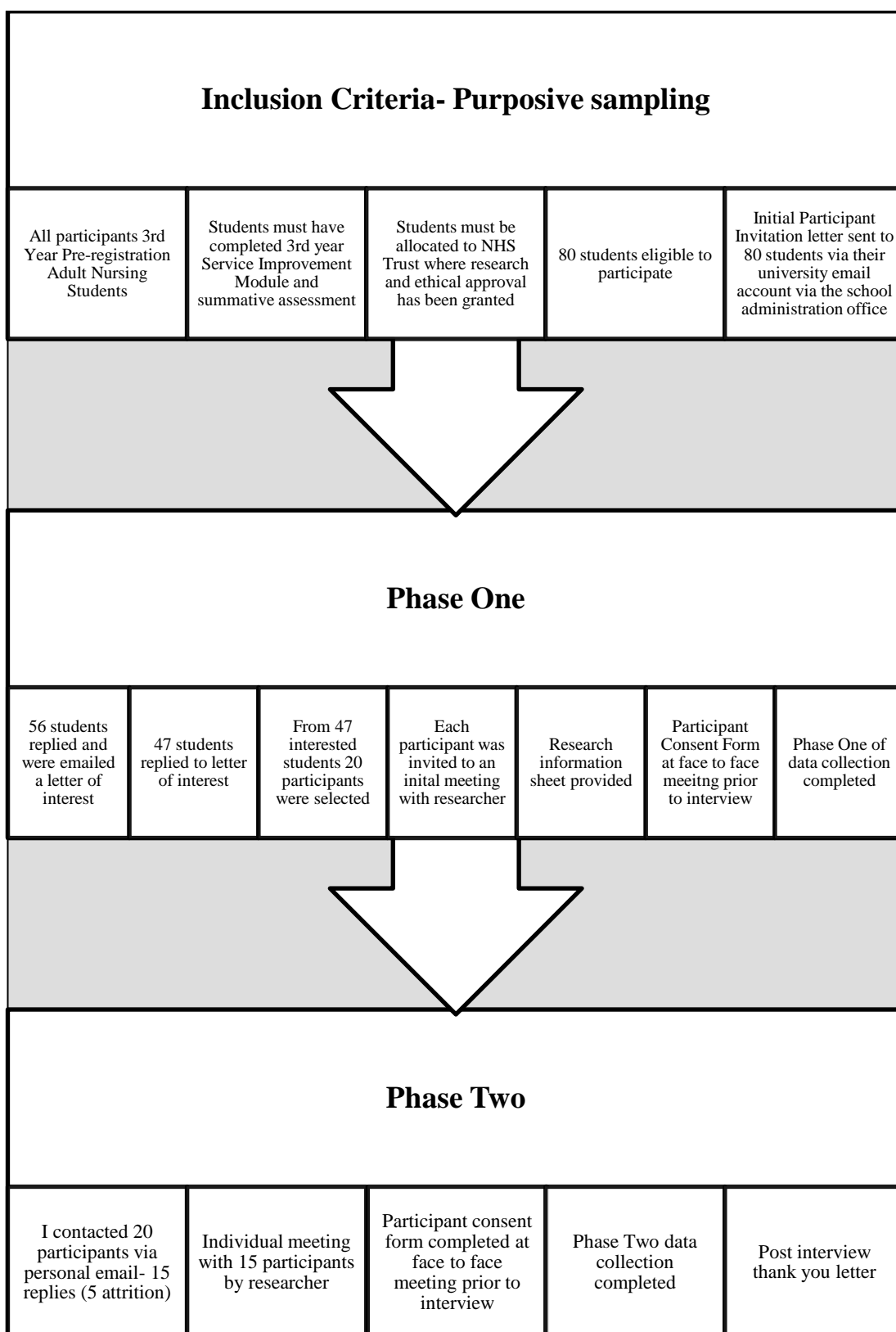
#### ***5.3.1 Purposive sampling***

Participants in this study were purposively sampled. Purposive sampling allows participants to be selected strategically, based upon the belief that the investigators knowledge about the population is important (Polit and Beck, 2010b). Purposive sampling allows selection participants in a meaningful way rather than attempt to make a representative sample (Denzin & Lincoln, 2002; Liamputtong, 2009). In interpretive research, purposive sampling is appropriate as it allows the researcher to select participants, as they can purposefully inform an understanding of the research question (Cohen, Kahn & Steeves, 2000; Cresswell, 2009). By sampling purposively there is no means by which to assess how typical the sample is (Polit & Beck, 2010b). Nevertheless, this is not a concern when using phenomenological methodologies, as the sample is always purposive as it must include those who have experienced the phenomena being investigated (Corben, 1999).

The aim of this study was to explore the participants' experiences of service improvement in nursing. Hermeneutic phenomenology allows for a detailed in-depth description of the phenomena to be shared by participants within their individual context (van Manen, 1997). Therefore, the sampling strategy in this study needed to include those participants who had experienced the phenomena of service improvement within their pre-registration nursing programme and later as registered nurses working in a local NHS Trust.

The purposive strategy for this research is illustrated in Figure 6:

**Figure 6 Sampling strategy**



There were three specific inclusion criteria for this research:

1. All participants must be third year adult nursing students.
2. All participants have completed the Service Improvement Module and undertaken the summative assessment of the module as part of their pre-registration programme.
3. All participants must be attached to the local NHS Trust where research and ethical permission for Phase Two of this research was granted.

Eighty adult nursing students met the inclusion criteria purposively set.

### *5.3.2 Sample size and participant selection*

Liamputtong (2009) argues that there is no set sample size in qualitative research; rather the sample size should be flexible. Sampling from five to twenty-five participants is often suggested for qualitative research methodologies which include phenomenology (Bagnasco, Ghirotto, & Sasso, 2014). The sample size should consider the depth of data sought and the intensity of contact with participants. Interpretative phenomenological studies are more likely to have smaller sample sizes since the analysis of data is so in-depth (Patton, 2002; Bryman, 2012). I read other studies with similar methodology and methods in order to examine other researchers' sampling strategies. Standing (2009) carried out a longitudinal hermeneutic study exploring experiences of student to registered nurses. Following the post-qualifying period, there was 50% attrition of participants (Standing, 2009).

In this study, 20 participants were purposively selected as they met the characteristics identified in the inclusion criterion. Phase One data collection occurred during the second semester of the third year pre-registration nursing programme, therefore all the participants were 21 years or older at the start of the study. The average age profile for nursing students in the UK at the start of this study was 29 years (Willis, 2012). Participants aged 23 and over are considered mature students (Willis, 2012).

### ***5.3.3 Recruitment of participants***

Following ethical approval from the university and the NHS Trust, 80 students who met the inclusion criteria, were contacted via their university email address by the school administration team. The email included a Participant invitation letter that asked for volunteers to participate in the research (Appendix 1). The letter identified the purpose of the research and the research approach. Fifty-six students answered the email and expressed an interest. These participants were sent a Letter of interest (Appendix 2) which provided further information. Forty-seven replied to this, indicating that they were willing to participant in this study. On return of these letters, the names of the 47 students were added to an Excel database and from this; twenty participants were selected from a computer-generated list.

Figure 7 illustrates the characteristics of the twenty participants and provides a reference, which allows identification of each participant through their unique identifying number.



**Figure 7 Participant characteristics**

Participant	Sex	Age at Phase One	Phase One Semester Two Third Year Nursing student	Phase Two 12 months later Registered nurse	Individual characteristics	Post registration post
P1	F	21	√	√	No previous care experiences	Cardiac care
P2	F	32	√	√	Mature student, previous HCA	Transplant unit
P3	F	32	√	√	Mature student, previous HCA	Out-patient clinic
P4	M	23	√	√	No previous care experiences	Renal transplant unit
P5	F	29	√	√	Mature student, previous HCA	General surgery
P6	M	25	√	√	Mature student.	Coronary Care Unit (CCU)
P7	F	22	√	×	No second interview.	Employed outside NHS Trust
P8	F	27	√	√	Mature student	Neurology Intensive Care Unit (NICU)
P9	F	22	√	×	No second interview	Employed outside NHS Trust
P10	F	21	√	√	No previous care experiences	Paediatric Intensive Care Unit (PICU)
P11	F	23	√	√	Previous retail experience	General surgery
P12	F	21	√	√	No previous care experiences	Cardiac Catheter Laboratory
P13	F	23	√	×	No second interview	Employed outside NHS Trust
P14	F	36	√	√	Mature student Previously Retail manager	General Theatre department
P15	F	29	√	√	Mature student, previous HCA	General medicine
P16	F	26	√	√	Mature student	Special Care Baby Unit (SCBU)
P17	F	23	√	×	No second interview	Employed outside NHS Trust
P18	F	32	√	×	No second interview	Employed outside NHS Trust
P19	M	28	√	√	Mature student	Intensive Care Unit (ICU)
P20	F	35	√	×	Mature student	Oncology

In order to protect the anonymity of the participants, no detailed demographic information is included within this thesis that may mean the participants could be identified. The participants are referred to as 'P' followed by their unique participant number. In Chapter 6, only their unique number and the data source as being Interview 1 or Interview 2 identify the participants.

The twenty participants who were selected, were invited to an initial face to face meeting with myself, where they received a Participant Consent Form (Appendix 3) and the Research information sheet (Appendix 4). A verbal explanation of the study was provided and I was able to answer any concerns or queries. The consent form was completed asking the participants consent for this phase of the study and also for permission to be contacted for Phase Two of the study. Phase Two of this study occurred 12 months later when the participants were newly registered nurses. All the participants gave their personal contact details and their future workplace details in the NHS Trust (for those who had already been offered a position when they became registered). Prior to Phase Two, the participants were contacted again using my university email address, asking if they were willing to participate in the second phase of this study. Fifteen participants replied to my email and subsequently had a face to face meeting with myself, where they were given further verbal explanation of the second phase of this study and were asked to sign a second consent form (Appendix 5) prior to being interviewed.

#### **5.4 Data collection**

Crotty (1998) argues the method of data collection must be congruent with the research methodology and philosophical assumptions of the research paradigm. This research used hermeneutic phenomenology that seeks to gain the in-depth experiences of the participants in the form of their own personal 'stories'. Semi-structured interviews are therefore an appropriate means of data collection (van Manen, 1997; Lopez & Willis, 2004).

I was the sole investigator for this study, nevertheless, this is not unusual in hermeneutic phenomenology; there is often only one researcher who will conduct all the interviews (Kleiman, 2004). This single researcher approach helps researchers develop a deeper understanding of the phenomenon (Kleiman, 2004). I am also an insider; insider researchers share features with the participants (Clarke & Braun, 2013) and have an advantage as they blend into the environment and this leads to 'thicker description' of the phenomenon by participants (Mercer, 2007).

Data collection was designed to gather the participants' experiences of the phenomenon of service improvement in nursing and was organised in two distinct phases:

1. Phase One data collection occurred during the second semester 3<sup>rd</sup> Year Pre-registration nursing programme, when the participants were student nurses in university.
2. Phase Two data collection occurred 12 months later when participants were newly registered nurses.

## **5.5 Data collection in hermeneutic phenomenology**

### ***5.5.1 Rationale for using semi-structured interviews for data collection***

In phenomenological research there are several different ways to collect data including unstructured and semi-structured interviews (Van Teijlingen & Ireland, 2003; Sloan & Bowe, 2014). Interviews are concerned with exploring knowledge related to specific phenomena that individuals describe through narratives of their lived experiences (Liamputtong, 2011). In phenomenological studies, data collection carried out through interviews, is a useful way of gathering individual reflective recollections (van Manen, 1997; Sloan & Bowe, 2014). van Manen (1990) describes this as 'borrowing' the stories of the participants as a means to develop understanding. This borrowing requires participants to reveal descriptive information through questions that are reflective in nature and propel participants to think of their experiences with the phenomenon (van Manen, 1997).

Phenomenological interviews differ from usual in-depth interviews as they establish 'conversational relationships' that develop trust and encourage mutual discovery (Liamputtong, 2011). Gadamer (1982) describes conducting phenomenological interviews as how:

*"We 'conduct 'a conversation, but the more fundamental a conversation is, the less its conduct lies within the will of either partner. Thus, a fundamental conversation is never one that we want to conduct. Rather it is generally more correct to say that we fall into conversation, or even that we become involved in it. The way in which one word follows another, with the conversation taking its own turning and reaching a conclusion, may well be conducted in some way, but the people conversing are far less the leaders of it than the led. No one knows what will come out of the conversation. Understanding or its failure is like a process that happens to us. All this shows that conversation has a spirit of its own and that language used in it bears its own truth within it, i.e. that it reveals something which henceforth exists" (Gadamer 1982, p.345)*

Lowes and Prowse (2001) argue phenomenological interviews need structure to ensure the data collected is relevant to the focus of the study. Wood (1991) suggests that during the interview, a single initial open question is all that is required as the interview will generate data with no further guidance to participants. However, Smythe et al., (2008) suggest researchers should use a semi-structured approach to interviews in phenomenological research. This allows researchers to be absorbed in the play of conversation and embrace the phenomenological spirit (Smythe et al., 2008). The researcher can focus on the phenomena as it is experienced by the participant (Flood, 2010).

Minichiello, Madison, Hays, Courtney and St. John (1999) suggest an informal conversational approach to interviews, permits participants to disclose their personal experiences and interpretations through meaningful discussion. Researchers are able to respond to situations during data collection and can adapt where necessary using creative and intuitive processes through effective use of interpersonal skills (Appleton & King, 2002; Cresswell, 2009).

Semi-structured interviews permit the researcher to use open-ended questions that enable the participants to respond in their own words (Polit & Beck, 2010). Open-ended questions allow the participant to give a rich description of their experiences in context to space and time, a notion which is consistent with Heidegger's concept of time and context-specific truths (McConnell-Henry et al., 2011). The participants are able to respond freely to questions and describe their individual experiences openly and without restriction (Morse & Field, 1995).

McConnell-Henry et al., (2011) support the use of single interviews, suggesting these are pragmatic in hermeneutic phenomenology as any further interview is incongruent with Heidegger's philosophy of time and being. A single, semi-structured approach to each individual interview is still a unique experience for the individual in space and time (Smythe, Ironside, Sims, Swenson, & Spence, 2008). Semi-structured interviews also allow the researcher the ability to compare findings between interviews as the questions are standard (Minichiello et al., 1999). This was a relevant consideration as this study was longitudinal. This research aimed to explore the participants' experiences of service improvement at two different times during their nursing careers. In this study, one single semi-structured interview per participant occurred. Phase One, when the participants were student nurses and Phase Two, 12 months later as newly registered nurses. Semi structured interviews allow the reconstruction of the past, the interpretation of the present and prediction the future (Lincoln & Guba, 1985). This is consistent with Heidegger's philosophy of time and being.

Interviews can be time-consuming and problematic to arrange for both the researcher and participants. Cresswell (2007) highlights the challenges of interviewing, including the challenges of conducting them due to time constraints and the physical location. Other considerations include travelling time and parking costs associated with the place of interview.

Using single interviews in this study, minimised costs in respect of travel expenses, parking charges and potential costs for room bookings in the local NHS Trust. Justifying budgets, grants and scholarships is paramount to successful completion of research (McConnell-Henry et al., 2011).

### ***5.5.2 The interviews***

Phase One interviews were conducted in university at a time and place which was mutually agreed with each participant. A quiet office, with a notice on the door to prevent distractions, was utilised on each occasion. Immediately prior to the interview, it was explained that I would be recording the interview digitally. The digital recorder was positioned in an unobtrusive spot to minimise it as a potential distraction. Each interview was digitally recorded with the participant's consent and was fully transcribed verbatim later. The transcripts included notes that were positioned alongside the text, taken at the time of interview. The interview notes recorded participant behaviours during the interview and my own reflexive thought processes; this is discussed later in this chapter.

Phase Two interviews occurred 12 months later when participants were employed in a local NHS Trust. All the interviews occurred on NHS Trust premises and were arranged mutually with the participants so that they were interviewed before or after their working day. This meant the participants had no additional costs attributed to taking part in this study through additional travel or parking charges. The NHS Trust provided the use of a private room for the interviews, which was free of charge. The rooms were pre-booked via the Lead Nurse for practice development and had a privacy notice placed on the door to prevent any interruptions.

Phase One interviews lasted from 7.32 minutes to 22.34 minutes. The average recording time was 15.43 minutes. In Phase Two, interviews ranged from 11.16 minutes to 24.23, the mean recording being 18.23 minutes.

### 5.5.3 The interview Schedule

An interview schedule was developed to facilitate the semi-structured interviews and was used in both phases of this study. Robson (2005) suggests that interview schedules should incorporate an introduction, a focussed lead question and several key questions or prompts. Each participant was asked the same opening question (1). At the end of each interview, the same final question (6) was asked. Figure 8 illustrates the interview schedule used:

**Figure 8 Interview schedule**

1. What does service improvement mean to you?
2. What do you understand about service improvement?
3. What experience have you had of service improvement learning?
4. What experience have you had of service improvement in practice?
5. Has there been anything in your service improvement experience that has changed the way you feel about it or the way you facilitate it?
6. Is there anything else you want to tell me about your role in service improvement?

van Manen (1990) suggests that due to the emergent nature of phenomenological interviews, it is difficult to prewrite a set list of questions in advance. Despite this, the use of an interview schedule can support researchers in the interview process and help focus the researcher and participants on the phenomena being investigated and uses the resources of the researcher and participants effectively (Lowes & Prowse, 2001; Smith et al., 2010). The interview schedule helped me focus on the interview and concentrate on what the participants were describing as their experiences of the phenomenon of service improvement (van Manen, 1997).

A three-method approach to interviewing was used as advocated by Minichiello et al., (1995). Minichiello et al., (1995) suggests funnelling, storytelling and probing as effective

mechanisms through which to conduct interviews. Funnelling is concerned with opening the interview with broad open questions. van Manen (1990) advocates this approach in that a single focused introductory question may start the conversational approach of semi-structured phenomenological interviews. Storytelling relates to the researcher encouraging participants to describe their story and experiences in their own words. This approach is also congruent to phenomenology, which seeks to understand the lived experiences of participant's. Probing was also used which facilitated clarification or further detail from the participant in relation to experiences they have described. By using 'how', 'who' and 'when', rather than 'why' questions, allows the participant to elaborate and clarify their own experiences (McConnell-Henry et al., 2011). This approach helped to maintain the focus on the phenomenon of service improvement as the participants experienced it and helped clarify their meanings in context. This is discussed later in this chapter.

During each interview, notes were taken recording the participant's behaviour and mannerisms alongside their verbal responses. This was a way to record non-verbal body language exhibited by the participants. The interview notes were useful during data analysis as I referred to these to understand the participant's non-verbal and verbal cues such as the use of pauses and hand gestures. For example, during Phase One, one participant (P7) was describing how they felt about service improvement in nursing. The participant used the words "horrible, horrible" (P7 Interview 1 *Line 83* Appendix 10). At this point, I recorded in my interview notes that the participant held their hands to their face and covered their eyes, not showing distress at being interviewed, but reflecting on stress they felt at the time. I asked the participant if they were happy to continue with the interview at this point and they replied that they were happy to proceed.

#### ***5.5.4 Member checking and hermeneutic phenomenology***

Member checking occurred with participants concurrently as part of each interview, during both phases of this study. Lincoln and Guba (1985) suggest member checking is important



in validation of research findings. However, there are conflicting viewpoints regarding the use of member checking in hermeneutic phenomenology. Member checking may be distressing or unwanted, and participants could forget or regret what they said or disagree with the interpretation (Bradbury-Jones et al., 2010; McConnell-Henry et al., 2011). McConnell-Henry et al., (2011) argue that interviews only present a snapshot of time and context to the experience and by revisiting this through member checking there is a potential threat to the rigour of the study. Nevertheless, with interpretive research there is no need to either prove or generalise findings, rather the aim is to uncover and understand the data as it is immediately recounted by the participant (McConnell-Henry et al., 2011). Some researchers argue member checking is a key feature of hermeneutic phenomenology (Doyle, 2007; Bradbury-Jones et al., 2010) which can occur as a one off event or continuously throughout data collection and the research process (Doyle 2007).

During each interview, I used a range of follow-up, probing and clarification questions alongside conversation nudges, in order to respond to what the participants were saying. Conversation nudges encouraged further participant thoughts, using for example, '*mmm*', '*oh*' and '*go on*'. I also used 'check' questions to determine how the participants were feeling during the interview to ensure they were happy proceeding. Examples included, '*are you ok?*', '*are you happy to continue?*', '*we have been talking now for a while, are you ok?*'. I also used some pre-set prompts to facilitate member checking with the participants and obtain further clarification during each interview as necessary.

Figure 9 illustrates some key phrases and pre-set prompts which were used during the interviews:

**Figure 9 Interview prompts**

That seems important to you. Can you tell me some more about that...?
When you said ..... How did that make you feel, can explain what you mean?
You mentioned.....can you explain that a little more.
You said .....Do you mean .....? Is that correct?
That is interesting ...can you tell me more about that?

The prompts were used to check my understanding and perceptions were consistent with that of the participants during each interview. Clarification questions were used, as it was preferable to seek clarification during the interview. This is appropriate with hermeneutic phenomenology where the interviewer may seek immediate clarification during the interview process rather than later (Bradbury-Jones et al., 2010; McConnell-Henry et al 2011). The aim of any interview is to gain an understanding of the participant's experience at that time (Stein-Parbury, 200). Through being cognisant of time and being, this reflected the hermeneutic phenomenological approach of this study that Heidegger advocates. This immediacy in clarification ensures data are co-constructed and reflects a shared understanding between the researcher and the participant (Stein-Parbury, 2009; McConnell-Henry et al., 2011). This process of member checking is congruent with van Manen (1990), who considers member checking as being integral to hermeneutic conversations between the researcher and participants; a reflexive exercise within the hermeneutic circle.

I was aware that during the interview, my body language and non-verbal communication was a factor and I used eye contact, nodding, smiling and giving verbal cues in order to reassure the participants and encourage them to share their experiences. This is consistent with Appleton & King (2002) who suggest that researchers are able to respond to situations

during data collection and can adapt where necessary using creative and intuitive processes through effective use of their interpersonal skills.

Alongside member checking, I also maintained interview notes and recorded my reflexive thoughts during each interview, Reflexivity was a constant feature throughout this study. I used my reflexive notes during data analysis to ensure the participants' voice and lived experiences were conveyed, alongside my own hermeneutic interpretation of the findings. Figure 10 provides an example illustrating the use of member checking, interview notes and my reflexive thoughts during the interview process:

**Figure 10 Hermeneutic interviewing, member checking and reflexivity**

Interview question 5 responses	Probing questions	Participant elaborations	Clarification	Interview notes	Reflexivity
<i>P14 “If you have a really good manager who with their communication skills gets everybody on board. If you don't have the higher management on board to facilitate your idea, it's not going to get any forward”</i>	Can you explain that a little more to me?	<i>P14 “There were always open lines of communication with the ward manager and the clinical lead which I found more than in any other placement. So I think that hit the nail on the head”</i>	Therefore, it is important to have a ward manager who listens to your ideas and helps you take them forward.		
<i>P14 “Yes from my own personal experiences where I had an idea with my mentor on the ward. The ward manager, when we went to her, was on board straight away for a number of reasons. But if she had not been on side to take it forward there were a lot of repercussions that could have ended up”</i>	Can you tell me more?	<i>P14 “Yes. They wanted to know what a student's thoughts where. When a student came in from the outside and saw how that ward was run she asked me particular 'you are a different set of eyes coming in what, is there anything that needs changing, what you have seen?’”</i>		Nodding head and smiling. Seemed to appreciate this response from ward manager	Aware that I could identify with valuing student nurses bringing new ideas to the ward
	How did that make you feel, can explain what you mean?	<i>P14 “It was good that at the end of my placement I said 'yes there is' I don't think I would have went forward with it [service improvement] if she [ward manager] hadn't have asked. But that's just how it was. She said 'you know you are the ones from university, you are the ones for the future, you are getting taught at university everything contemporary and I want to know that and what they are saying’</i>	So the ward manager seemed to be important to your service improvement experiences.	Smiling, nodding head in agreement	
<i>P14 “Yes there are positives; actually you need to have confidence in yourself and what you do. I'm not a person who has a lot of confidence. Its grown and I'm learning but with that particular idea I did I had a good relationship with the ward manager. We would just talk and we would have these little discussions every week and she just asked me if there were any changes I had thought of. It was her and her communication skills that got that [service improvement] out of me”</i>				Nodding head	Conscious I was identifying with the importance of relationships and discussion. Recall this during analysis and use the evidence in the data and code according to data that rather than my thoughts

## **5.6 Data analysis**

When selecting a process for data analysis, several different approaches are congruent with phenomenology. Colaizzi (1978) and Giorgi (1970) developed data analysis methods considered appropriate for phenomenological studies (Edward & Welch, 2011). However, Colaizzi's and Giorgi's approaches are more aligned to Husserlian phenomenology, which is concerned with the participants meaning but do not consider the research interpretations (Polit and Beck 2010). These approaches to data analysis are not congruent with hermeneutic phenomenology. The intention of this study was to go beyond descriptive analysis and seek understanding of the lived experience of participants. As such, data analysis must reflect the principles of hermeneutic phenomenology and be consistent with the philosophical assumptions of an interpretive paradigm (van Manen 1997).

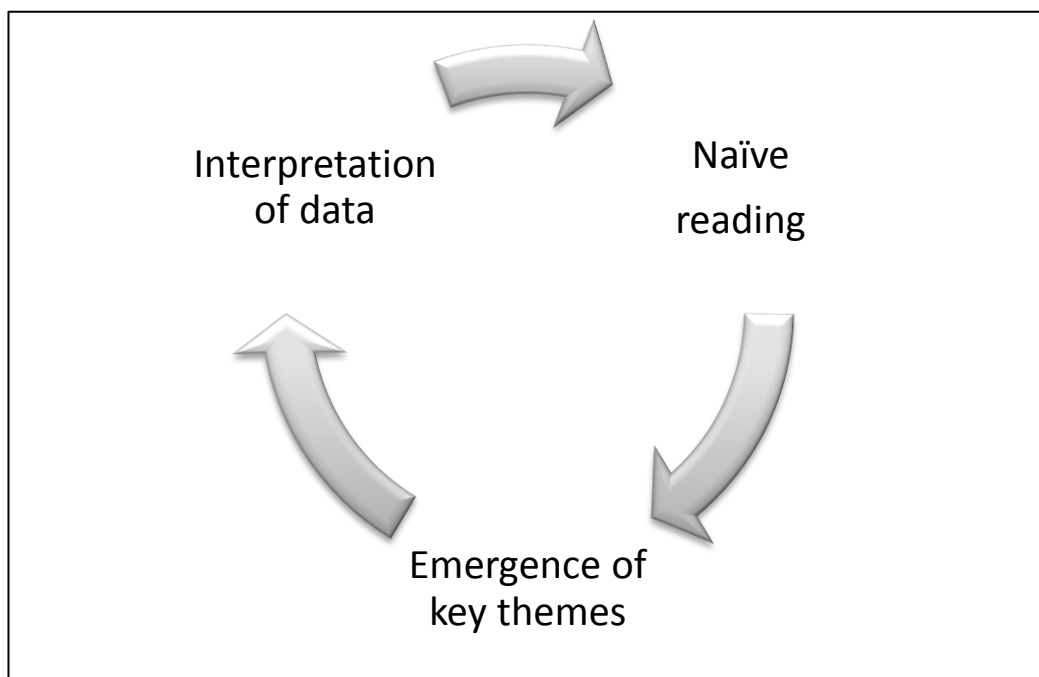
### ***5.6.1 Data analysis in descriptive and interpretive phenomenological research***

Hermeneutic phenomenology enables the participant's voice to be heard and provides rich descriptions of their experiences. The focus is on the meaning of differing participant accounts, with the aim of describing the phenomenon, 'to grasp the very nature of the thing' (van Manen, 1990, p 177). Interview transcripts require interpretive analysis by the researcher (van Manen, 1997) in order to produce a phenomenological description of the participant experience (Sloan & Bowe, 2014). As such, researchers need to convey the existential, emotive, enactive, embodied, situational and non-theoretic understanding gained through phenomenological interpretation (van Manen, 1997). The aim of this study was to go further than describing the participants' experiences of the phenomena, it was to make explicit the meaning that was felt through interpretation (van Manen, 1990). van Manen (1990) proposes that in hermeneutic phenomenology, the researcher is integral to this interpretation.

## 5.7 Using the hermeneutic circle to aid data analysis

In order to navigate the hermeneutic circle, the researcher needs to engage in three stages; naïve reading, emergence of key themes and interpretation of data (Lindseth & Norberg, 2004). Each stage of this process allows for partial understanding, leading to further interpretation. The process is iterative with movement between parts (data) and the whole (evolving comprehension of the phenomenon) and where each gives meaning to the other (Ajjawi & Higgs, 2007). Figure 11 illustrates three stages of engagement in the hermeneutic circle:

**Figure 11 Lindseth & Norberg's (2004) stages of engagement in the hermeneutic circle**



The first stage of the hermeneutic circle requires the researcher to conduct initial naïve reading. In this stage, interview transcripts were read several times to grasp their meanings. Naïve reading considered first order constructs, which were the participants' ideas, expressed in their own words or phrases and which captures the exact detail of what the

participant was verbalising (Titchen & McIntyre, 1993). It was important that I remained open to the data so the text was able to 'talk' to me, in an effort to obtain naïve understanding (Ajjawi & Higgs, 2007). Through re-reading and naïve understanding, I was able to identify initial concepts, systematically, from the participant's first order constructs (Titchen & McIntyre, 1993; Ajjawi & Higgs, 2007).

Stage two of the hermeneutic circle concerns the emergence of key themes. A theme describes an aspect of the experience or phenomena (Van Manen 1990). The themes and sub-themes were generated using the participant data as first order constructs (Ajjawi & Higgs, 2007)

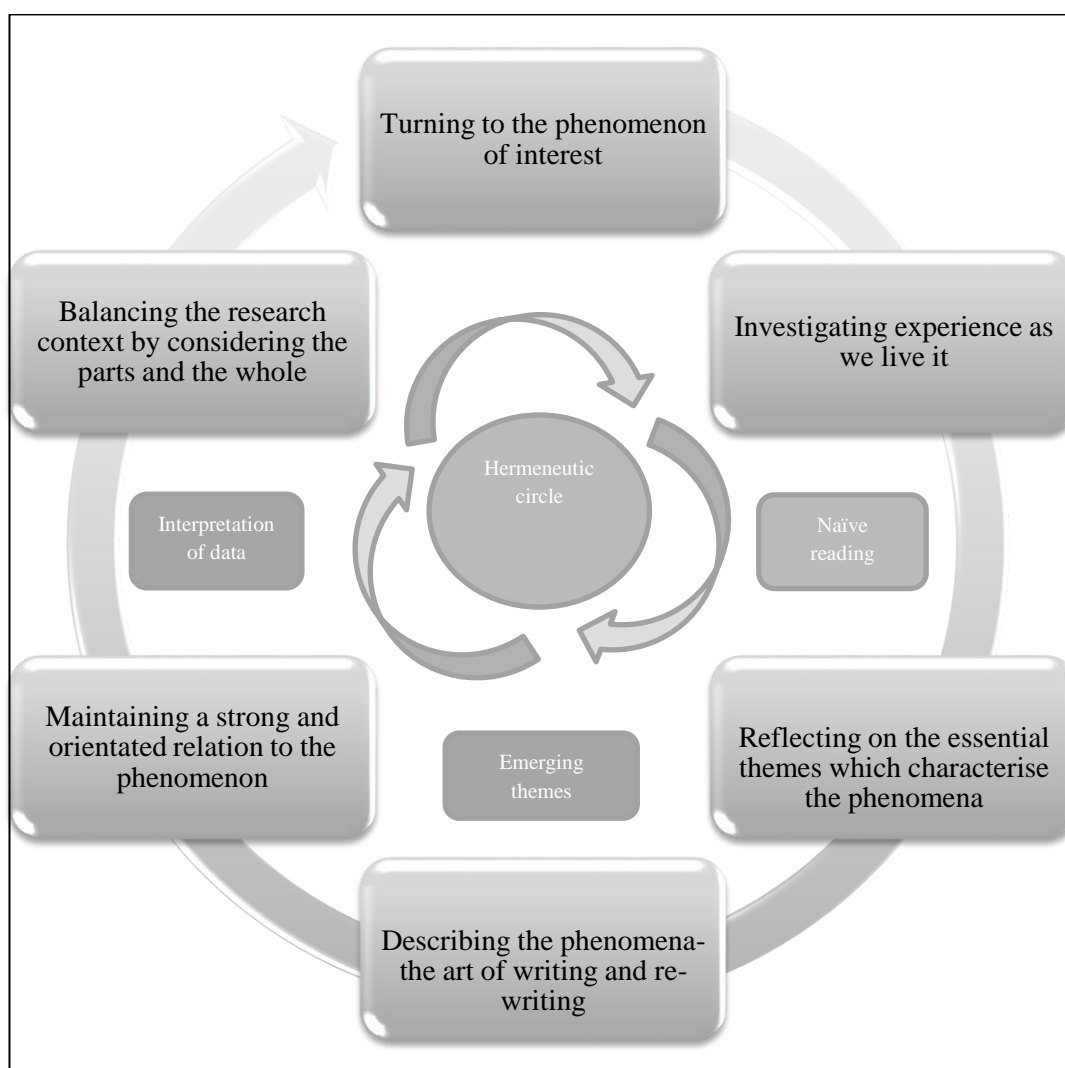
Stage three of the hermeneutic circle involves interpretation of data. Corben (1999) describes hermeneutic interpretation which emerges through the participant's rich description of the phenomenon and which conveys the meaning of their lived experience (Graneheim & Lundman, 2004; Polit & Beck, 2010). Re-reading and interpretation of the transcripts facilitates a systematic analysis of the participants' experiences (Ajjawi & Higgs, 2007). My own interpretations or second order constructs, were my own interpretations and abstractions of the first order constructs (Titchen & McIntyre, 1993) and are an integral part of hermeneutic phenomenology (Heidegger, 1962). Interpretation is dependent on the researcher and the research context (Koch, 1996). Consideration of the research context allows a more powerful understanding of the participant's experiences and is central to the interactions between the researcher and participants as the research progresses (Ajjawi & Higgs, 2007). Each theme and related sub-theme was explored using relevant literature. This process located the research findings within the existing body of literature and supported the initial theoretical development (Titchen & McIntyre, 1993; Ajjawi & Higgs, 2007). This approach is consistent with hermeneutic phenomenology and facilitates effective analysis and new theoretical development (Titchen & McIntyre 1993, Ajjawi & Higgs, 2007).

These stages of the hermeneutic circle are intrinsic to van Manen's (1990) approach to data analysis and support a cyclical interpretation of data, allowing me to be wholly absorbed in the analysis of findings.

### 5.8 A van Manen approach to data analysis

van Manen's (1990) approach to data analysis was used, as this was congruent with hermeneutic phenomenology. Figure 12 illustrates van Manen's (1990) approach to data analysis, which provided me with a systematic and workable method to analyse data using the hermeneutic circle:

**Figure 12 van Manen (1990) data analysis and the hermeneutic circle**





van Manen's (1990) six activities are conducive to analysing hermeneutic phenomenological data. The activities allow a structured and sequential process to facilitate analysis (van Manen, 1990; Polit and Beck, 2010). However, it is important researchers avoid fixed signposts during data analysis, as these may not support the flexible philosophy underpinning hermeneutic phenomenology (van Manen, 1990). Each stage of data analysis occurred in this study, however, in reality there was flexibility between the stages. It was not a linear process and I frequently returned to the hermeneutic circle for naive reading, re-reading and interpretation of the transcripts throughout each stage of data analysis. Gadamer (1979) supports this approach, suggesting that movement between the six activities, both forwards, and backwards, allows researchers the time to consider, re-consider and reflect on the parts and whole. It is through these activities that the researcher can fully engage in the hermeneutic circle (Gadamer, 1979). Through an ongoing hermeneutic process of data analysis, the researcher is able to identify convergent and divergent viewpoints (Appleton & King, 2002). Figure 13 summarises data analysis activities applied to this study alongside my research journal notes, reflexive thoughts and actions:

**Figure 13 van Manen activities of data analysis applied to this research**

Activities of data analysis	Application of activity to study	Hermeneutic circle, research journal notes and reflexivity
Turning to the phenomenon of interest	Recognising the phenomenon is an area of interest to me as a researcher  Commitment to understanding the phenomenon through research	Acknowledging my own service improvement experiences, values, beliefs. Recognising my fore-structures foresight and fore-conception
Investigating experience as we live it	Data collection semi-structured interview  Verbatim transcription of digital recordings	Using interview notes, reflexive thoughts. Revisit interviews using hermeneutic circle (naïve reading)
Reflecting on essential themes which characterise the phenomena	Listening to digital recorded interview simultaneously reading interview transcripts  Identifying participant first order constructs  Initial concepts from data coded as nodes NVivo™ used for organisation of thematic frameworks during Phase One and Two  Initial interpretation of findings in the emergence of initial themes	Recognising my own service improvement experiences, values, beliefs and fore-structures Data driven coding using NVivo™ nodes to identify participants first order constructs Revisit interviews using hermeneutic circle (emerging themes)
Describing the phenomena- the art of writing and re-writing	Line by line analysis of transcripts  Re-reading and listening to the transcripts  Reflection on initial themes which characterise the phenomena	Identify initial emerging themes and sub-themes Reflexivity, acknowledging my own fore-structures, experiences and beliefs to ensure it is the participant voice being heard Rechecking transcripts by line by line analysis against nodes and initial themes and sub-themes using hermeneutic circle (emerging themes)
Maintaining a strong and orientated relation to the phenomenon	Key themes and sub-themes considered in relation to the overall research aim  Development of second order constructs by researcher  Assimilation of literature relevant to the findings	Expansion of initial literature review to incorporate emerging themes and sub-themes, allowing second order constructs to be layered with literature Reflexivity of my own fore-having, foresight and fore-conception in order to understand and interpret the meaning of data Overlaying interpretation of findings with literature Initial theoretical development (using the hermeneutic circle and interpretation of findings)
Balancing the research context by considering the parts and the whole	Revisiting the findings and phenomenon as parts and with the whole  Emergence of a new theoretical model	Revisit the findings. Pulling the ‘parts’ together, using the initial theoretical development, (expansion of literature review to incorporate initial theoretical development) and developing a ‘whole’ new theory

### ***5.8.1 Turning to the phenomenon of interest***

The first stage of data analysis, turning to the phenomenon of interest was discussed in chapter 1. This study stemmed from my personal interest and desire to understand the phenomenon of service improvement in nursing. Converse (2012) argues researchers must recognise their own fore-having, fore-sight and fore-conception in order to understand and interpret the meaning of data. In order to be reflexive, I identified my own experiences, fore-structures, beliefs, values and knowledge in service improvement in nursing which is discussed later in chapter 8.

### ***5.8.2 Investigating experience as we live it***

The process of investigating the experience as it is lived it rather than as it was conceptualised, occurred through the interview process (van Manen, 1990). The use of semi-structured interviews gave the participants the opportunity to describe their lived experiences of service improvement as students and later as registered nurses. van Manen (1990) suggests researchers:

*“Must investigate and explore all aspects of the experience as it is lived it rather than conceptualise it” (van Manen 1990, p. 30)*

Participants in this study articulated their experiences in their own words in order to share their perceptions and experiences. Interview notes were taken during each interview that added depth to my understanding of the participant experience. I transcribed each individual interview verbatim. Full verbatim transcribing allows the participants own words to be presented, which portray their lived experiences. An example of a full interview transcript is provided in Appendix 10 of this thesis.

Full transcriptions reduce the risk of any crucial information being lost in context, which can make interpretation harder during data analysis (Gibbs, 2011).

Despite this being time consuming, this was a useful exercise in this study as transcribing each interview allowed me to be fully immersed in the data.

### ***5.8.3 Reflecting on essential themes which characterise the phenomena***

van Manen (1990) suggests reflecting on essential themes that characterise the phenomena, allows significant experiences for the individual to be identified, and:

*“makes a distinction between appearance and essence, between the things of our experience”* (van Manen 1990, p.31)

I developed thematic frameworks for both phases of this study that facilitated coding of data. The interview transcripts were re-read, line by line, several times to identify participant first order constructs that were coded as nodes in NVivo <sup>TM</sup>. I purposefully used the participant words as nodes in order to remain close to the phenomena and describe service improvement as how the participants lived the experience.

Figures 14 illustrates the thematic framework developed for Phase One of this study, using participant quotes (first order constructs) in order to inform the nodes:

**Figure 14 Thematic Framework Phase One**

Name	Sources	References
ward manager as gatekeeper to SI	13	36
staff blocking SI	19	99
mentor involvement with student and SI practice	12	31
receptiveness to change	7	14
student practice experience in service improvement is variable	11	38
student understanding of the concept of service improvement	18	33
students learning about SI in university	20	71
student theory practice gap	16	33
Students motivation to learn more	7	13
what skills and characteristics, knowledge is needed to undertake SI	19	69
currency as a student undertaking SI	12	22
socialisation, heirarchy and power within practice affects students ability to undertake SI	13	44
students percieved as a threat by staff	7	12
being an outsider	15	30
Not wanting to be the 'unpopular student'	9	22
ward culture	15	40
Powerlessness	13	27
heirachy and currency of older staff and changing practice	7	12
being a dogs body	2	3
ritualistic practice- blinded by routine	16	38
a fresh set of eyes	10	18
student concerns about their ability to do SI	13	27
fear of failure	10	15

This approach is congruent with using thematic frameworks, which are descriptive and attached to priori issues. Nevertheless, thematic frameworks enable researchers to recognise emerging themes, which appear though recurrence or patterning of experiences (Richie and Spencer, 1994).

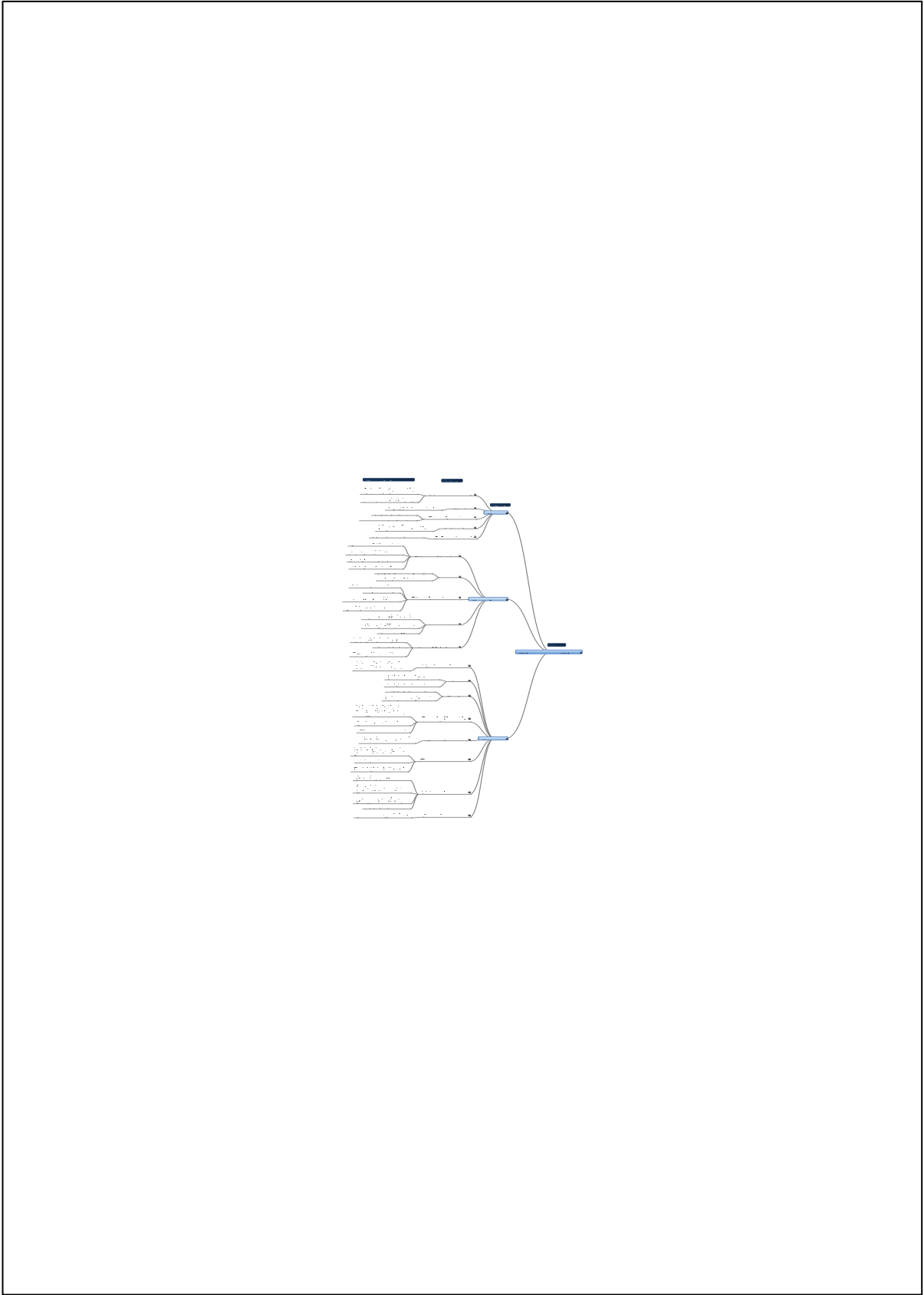
From this initial descriptive phase, researchers can use thematic frameworks to identify concepts that encapsulate the participant's experiences. The thematic frameworks helped me to refine the emerging concepts into four key themes and related sub-themes. Richie & Spencer (1994) suggest thematic frameworks are more than a mechanical process, they require initiative and logical thinking where the researcher must make judgements about meanings, relevance and connections.

#### ***5.8.4 Describing the phenomena- the art of writing and re-writing***

The phenomenon of service improvement was described through a process of writing and re-writing. On-going reading and re-reading of transcripts, using the hermeneutic circle, alongside listening to the digital recordings occurred. This process allowed for the transcripts and digital recordings to come 'to life' and allow the participant voice to be heard (Lichtmann, 2006). This allowed full immersion in the data in order to develop an initial interpretation of what was being described by the participants.

From this immersion, sub-themes and themes were emerging (van Manen, 1997; Cresswell, 2007). van Manen (1997) describes themes as being existential and discusses themes in relation to lived space (spatiality), lived body (corporeality), lived time (temporality) and lived human relation (relationality). Sloan and Bowe (2014) discuss 'existentials' as being theme types that act as guides for reflection during data analysis. In this study, the data was explored using the context of where and when the participants were experiencing the phenomenon of service improvement in nursing (spatiality and temporality). I could understand how the participants perceived service improvement (corporeality) and the factors that influenced their relationships (relationality). It was important that I remained reflexive during this stage so that the participant voice was heard from the findings (Figure 13, p.132). Mind Genius 4 <sup>TM</sup> was used to produce mind maps. Figure 15 provides an example overview of a mind map showing the development of Theme Three based on participant quotes from Phase One of this st

Figure 15 Theme Three development



The subthemes in Figure 15 are illustrated more clearly in Appendices 7, 8 and 9.

### 5.8.5 Maintaining a strong and orientated relation to the phenomenon

NVivo™ word clouds were useful to identify key words and concepts that the participants identified; this helped maintain a strong orientation to the phenomenon of service improvement. Figure 16 illustrates an example of a word cloud:

**Figure 16 NVivo Word Cloud, Phase Two**



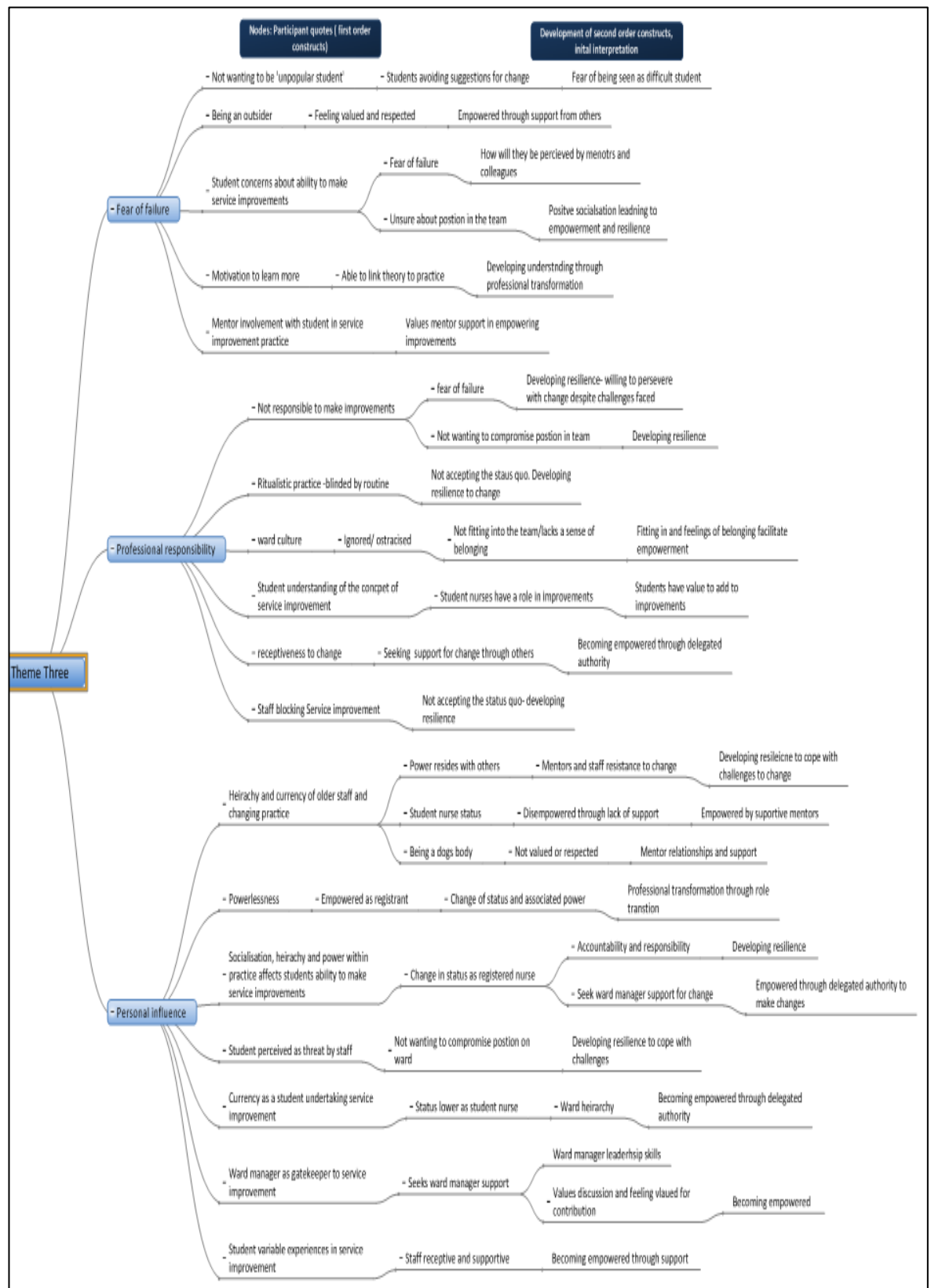
The identified themes remained closely orientated to the phenomena of service improvement as participant quotes were aligned to the emerging themes and sub-themes in order to facilitate the process of analysis. Through an iterative process, the themes and sub-themes, which permeated the participant's transcriptions, conveyed the meaning of their lived experiences (Polit & Beck, 2010b).



The use of interview notes facilitated the process of interpretation and analysis of the findings. The interview notes enabled me to interpret verbal and non-verbal cues and nuances alongside the transcripts. For example, participants sighed and laughed at times during the interviews. This activity allows for a richer and deeper understanding of the participants experiences and is central to the interactions of the researcher and participants as the research progresses (Ajjawi & Higgs, 2007).

Further analysis of the themes and sub-themes facilitated the development of second order constructs. During this stage of data analysis, I reflected on the initial themes and sub-themes in context of my own experiences and existing underpinning theoretical knowledge (Ajjawi & Higgs, 2007). I remained reflexive, conscious of how my own experiences, perceptions and theoretical knowledge may influence my interpretation of the data. Initial theoretical development involved developing the second order constructs into recognisable concepts, which would be relevant to service improvement in nursing. Literature was used to support the summative discussion of each theme and facilitated initial theoretical development. Figure 17 illustrates development of a mind map of second order constructs and initial theoretical development using Theme Three as an example:

**Figure 17 Three: Power and powerlessness, development of second order constructs and initial theoretical development**

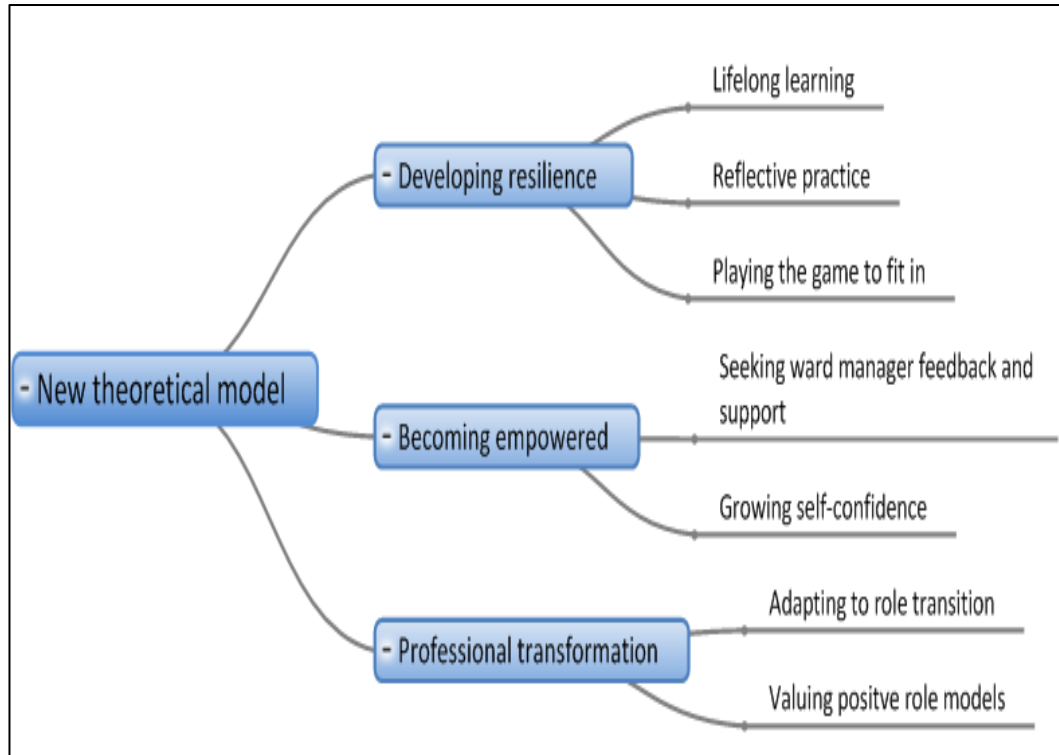


#### ***5.8.6 Balancing the research context by considering the parts and the whole***

The final activity which van Manen (1990) requires is balancing the parts of the research in consideration of the whole. The hermeneutic circle was used in order to move backwards and forwards, revisiting the findings, transcriptions and literature in order to facilitate deeper understanding and support my interpretation of what the participants were experiencing. This iterative and hermeneutic process facilitated analysis of findings whilst maintaining a focus on the research aim, within the context of this study (van Manen, 1990). Initial theoretical development was summarised and reflected on in relation to the research aim and objectives; orientated within the context of the research. I was continually being reflexive, using my experiences, beliefs, knowledge and fore-structures to aid interpretation of the findings. Interpretation occurs with the researcher being part of the social, historical and political world (Converse, 2012).

The literature review was expanded to include new relevant research and literature to deepen understanding of the text and to review the relevance of themes in context (van Manen, 1990; Lindseth and Norberg, 2004). This occurred through a methodological process of moving between parts of and the whole text in order to gain analysis and understanding (Polit and Beck, 2010). I used the hermeneutic circle, facilitating deeper understanding of the phenomenon and development of my initial interpretations of the data. From this deeper analysis and synthesis of literature, the initial theoretical development was reconsidered in context of the parts and whole (van Manen, 1990). Figure 18 illustrates the initial theoretical development, considering the parts and the whole new theoretical model which emerged from analysis of findings:

**Figure 18 From the ‘parts’ (initial theoretical development) to the ‘whole’ (new theoretical model)**



This final stage of data analysis culminated in the development of a new understanding of the phenomenon of service improvement in nursing which is discussed in chapter 7.

## **5.9 Handling the Data: reflections on the use of NVivo <sup>TM</sup>**

Data collected during this research was extensive. The Computer Assisted Data Analysis Software (CADAS) programme, NVivo <sup>TM</sup> was used. However, there is much debate both positive and negative as to the use of CADAS in qualitative research (Huberman & Miles, 2002; Bergin, 2011; Bazely & Jackson, 2013). Using CADAS takes time for researchers to become proficient in using the software, in doing so they can become distant from the data and have a reluctance to change categories once they have been developed (Bergin, 2011). Clarke (2009, p.70) argues that manual coding allows an ‘intimacy that cannot be achieved

otherwise'. Nevertheless, Huberman & Miles (2002 ) argue that those researchers who do not use CADAS beyond word processing, are hindered in comparison to those who do.

Despite concerns about using CADAS, Bazeley and Jackson (2013) argue that NVivo™ is not intended to replace traditional ways of learning from data; rather NVivo™ increases the effectiveness and efficiency of such learning. NVivo™ can also help researchers through effective use of their time and more efficient data management (Bergin, 2011; Richie & Spencer, 1994; Bazeley & Jackson, 2013). My learning and familiarity with NVivo™ developed over the whole of this research process. This learning was a valuable exercise as I became more comfortable with using the software, making NVivo™ work for me as the researcher and supporting data management and analysis of findings.

NVivo™ allowed for participant digital recordings and interview transcriptions to be organised in one single repository. Researchers using NVivo™ arguably lose closeness to the data through poor screen display, segmentation of the text and loss of context (Bazeley & Jackson, 2013). However, I was conscious that I needed to remain close to the data. As such, I relied on the hermeneutic circle which van Manen (1990) described as the underpinning approach to data analysis. During data analysis, the transcripts and interview notes (visual data), alongside the digital recordings (audio data) were constantly revisited as part of the hermeneutic circle. This approach to data analysis is congruent with Bazeley & Jackson (2013) who suggest that combining digital and visual data together can facilitate deeper analysis of findings.

NVivo™ was used to develop thematic frameworks for both phases of this study. Richie & Spencer (1994) suggest that thematic frameworks help the researcher to sift and sort data, allowing them to analyse the findings through identifying key issues, concepts and themes. The initial coding was a descriptive phase, where the thematic frameworks were used to identify first order constructs from the participants during both phases of this research. The thematic frameworks became more responsive to the emerging themes and

facilitated my conceptualisations and interpretations of the findings. Using the thematic frameworks was a useful process as it allowed me to be hands on and intimate with the data, enabling me to interpret the verbal nuances alongside listening to the recordings and reading the transcripts and written notes. NVivo <sup>TM</sup> further supported data analysis by allowing me to develop mind maps and word clouds to query data, model new ideas and report the data (Bazeley & Jackson, 2013).

## **5.10 Ethical considerations**

### ***5.10.1 Ethical approval***

The ethical considerations underpinning this study were based on the British Educational Research Association (BERA) 2011 guidelines. BERA (2011) stipulates that all educational research should consider the following principles, including respect for:

- The Person
- Knowledge
- Democratic Values
- The Quality of Educational Research
- Academic Freedom

The Northumbria University Ethics Committee and a local NHS Trust's Research and Development (R&D) department granted approval for this research (Appendices 11 & 12). Dual ethical approval was necessary as the second phase of this research involved the participants as registered nurses employed in the local NHS Trust. The NHS Trust required several assurances, which included Northumbria University Ethics Committee approval, NHS Trust R&D permission, agreement from the Director of Nursing of the NHS Trust and obtaining participant consent prior to Phase Two interviews. External researchers who

are collecting or transferring personal identifiable data outside of the NHS organisation are also required to have 'Caldicott approval' (Great Britain. Department of Health, 2013).

Caldicott approval applies to all research involving the collection of data from patients or staff and ensures an appropriate balance between protecting individual personal information and the use and sharing of information (Peate, 2013). I therefore applied for, and received Caldicott and Data Protection approval.

#### ***5.10.2 Participant safety***

It is important that all research be conducted within ethical principles designed to protect the participants. The four principles of ethics encompass autonomy, non-maleficence, beneficence and justice and underpin all research with human subjects (Beauchamp and Childress, 2001). Non-maleficence and beneficence encompass doing good and not inflicting harm. As a registered nurse, I am required to abide to my professional Code of conduct which has safety as an underpinning principle (NMC, 2015). In order to protect and care for the participants of this research I was able to use my experience as a registered nurse and Specialist Community Public Health Nurse (Health Visitor). I have established excellent communication skills, developed over a 32-year nursing career. I am able to recognise signs of stress and distress and I am confident I would have been able to identify any signs of distress the participants may have been exhibiting during the research process and interviews.

During Phase One, the participants had access to the University student support and occupational health services if required. None of the participants displayed any sign of stress or distress during their interview. However, if required I could have offered support, explanation or clarification and advised them to seek support from occupational health. The participants were registered nurses during Phase Two of this study and would have signed a declaration of good health as part of their NMC registration (NMC, 2015). The

participants had therefore self-assessed their own health as being satisfactory prior to being involved in this research.

I was able to signpost participants to additional support through their preceptorship programme, ward manager or through the NHS Trust occupational health service if this had been required.

### ***5.10.3 Researcher and participant relationships***

Phase One of this research involved interviewing the participants as third year adult student nurses. As a senior lecturer in the university where the participants were studying, I was able to access the potential study sample readily through the university administration team. The participants were invited to take part in this research through an initial invitation letter (Appendix 1). Those who expressed an interest in taking part in the research received a Letter of Interest (Appendix 2). The participants were offered an individual meeting where I was able to obtain their informed consent (Appendix 3) and provide them with further written information about the research (Appendix 4).

This initial one to one meeting allowed me to start and develop a relationship with the participants. However, as the researcher I was cognisant of my position as a university lecturer and wanted to minimise any potential bias and power disparity. Obtaining any sort of data in research is not a neutral activity as researchers change the dynamic of the situation (Bazeley, 2013). McConnell-Henry et al (2011) suggest there may be a ‘halo’ effect where participants feel they may be compared to other participants by their responses or may say what they think the researcher wants to hear (McConnell-Henry et al., 2011).

All the participants had already completed a service improvement module and had completed the module summative assessment prior to participating in this research. I had not been involved with any teaching or marking on the service improvement module that the participants had completed. I made it very clear the participants were under no



obligation to continue to be involved in the study if they did not wish to and that I was not going to be involved in any future teaching or marking of their academic work.

This minimised any potential conflicts, power differential or potential bias. In addition, the university has a system of anonymous marking for assignments that prevents the potential for any bias in any future marking I may have been involved with for students who may have been participants in this research.

During the individual semi-structured interview, I was aware of potential power dynamics that might be a consideration of this research. Research interviews are not open dialogue between egalitarian partners; rather there is power asymmetry between the researcher and participant (Kvale, 2011). Whilst power imbalance is not intentional it may still mean participants tell the researcher what the participant believes the researcher wants to hear (Kvale, 2011). However, with interpretive research participants may benefit from being treated as equal in the research process and they may be interested to hear the researchers interpretation of their accounts (Doyle, 2007; Bradbury-Jones, Irvine, & Sambrook, 2010). I made a conscious effort to develop a good rapport with participants before and during the interviews. Interactional skills and developing a rapport helps put the participants at ease (Clarke & Braun, 2013) Using a semi-structured approach and member checking helped me to obtain rich descriptions of the participants' experiences and clarify any areas that needed further understanding.

#### ***5.10.4 Informed consent***

Participant consent was obtained prior to both phases of this study before data collection during a face-to-face meeting. This is known as process consent (Barbour, 2007). Informed consent is central to ethical considerations in research and considers four fundamental elements namely disclosure, comprehension, competence and voluntariness (Franklin, Rowland, Fox, & Nicolson, 2012).

Firstly, disclosure demands that adequate information is provided to participants. In this research all the participants were given information regarding the research process through the Research information sheet (Appendix 4) at an individual meeting which took place prior to both interviews. This 'disclosure' ensured participants had relevant information about the research. I used this meeting as an opportunity to explain my study verbally as well as giving the participants written information that they could read later. Behi and Nolan (1995) support this approach, suggesting written information should be reinforced with verbal discussion so information is understood and shared honestly. Through this shared process, I was able to assess the 'comprehension' of participants. This stage of informed consent considers the importance of participants understanding the information. I was able to answer questions and clarify any issues the participants may have raised. 'Competence' is the ability of participants to make rational decisions. I explained the research process verbally to participants during a meeting and gave them the opportunity to ask any questions. Through this process, the participants were able to make a competent judgement on whether to participate or not. Finally, 'voluntariness' is concerned that there is no coercion applied to participants. The Research information sheet (Appendix 4) provided details about participation and withdrawal from the study. The participants were advised that non-participation or withdrawal would have no impact on their continuing on their pre-registration programme. Through signing the consent form, the participants were volunteering to take part in this research.

Meeting the participants prior to taking part in the interview was a process repeated in the same manner for Phase Two of this research. This process was to obtain a signature from participants and ensure ongoing informed consent (Appendix 5) and also offer an opportunity for clarification of any queries the participants may have in regard to Phase Two.

Following each phase of data collection, each participant was sent a letter of thanks via email within 48 hours of their interview (Appendix 6).

#### ***5.10.5 Confidentiality***

In order to maintain confidentiality all participants must be fully aware of the research process and have a choice to contribute or not (Swinton, 2009). Information provided through research information letters should describe the research as fully as possible (Barbour, 2007). In this study, each participant received a Research information sheet (Appendix 4) which detailed the study and issues such as confidentiality. In addition to this written information, the participants received verbal explanations prior to each interview during a face-to-face meeting.

There was a possibility that participants may have disclosed information that affected their professional suitability or caused concern regarding issues in practice. The Research information sheet provided information on this (Appendix 4). All the participants were informed prior to Phase One of the study about the University Whistle Blowing policy. During Phase Two, as registered nurses, the participants were all employed in the local NHS Trust and were advised of their NHS Trust policy for sharing concerns. Each participant was allocated a unique identifier number that was individual to him or her. This number identified each participant and was used throughout this thesis, to identify them and his or her quotations from the interview transcripts. No participant names are disclosed in this thesis or will be used in any reports, presentations or papers produced as a result of this study.

#### ***5.10.6 Withdrawal and attrition***

When consenting to take part in this study, the participants were advised they could withdraw from the study at any stage and this would not affect any future relationship with myself as the researcher or their pre-registration education. If any participant withdrew

from the research, all the data related to that participant would be destroyed, as confidential waste and deleted from the database. No participants formally withdrew from the research.

Participant attrition was a risk to this research as the two phases of data collection occurred 12 months apart. It was essential as the researcher that I established good relationships with participants in order to promote on-going contact with them once they were registered and working in the local NHS Trust. For Phase Two, potential of attrition was due to participant's changing their personal contact details. If this occurred, it would not have been possible to contact them. The attrition rate in this study was 25% with 15 participants taking part in Phase Two. Five participants did not participate in Phase Two as they had gained employment in other NHS organisations. In accordance with ethical approval, they were therefore excluded from the study.

#### ***5.10.7 Management of data***

Throughout this study, I have been conscientious and robust in data management. This not only ensured efficient retrieval of information but also that any form of data was handled safely. All written information regarding the participants was stored securely. Written information was stored in a locked filing cabinet, in a locked office. The office was secure with a locked door that had a secure electronic key fob for access. The office was situated in a building with access codes as the only means of gaining access and is covered by electronic alarms and security patrols.

All written information related to this research will be destroyed through confidential waste after ten years in consideration of The Research Council (Research Council UK, 2009) guidance which states:

*"Data should normally be preserved and accessible for ten years, but for projects of clinical or major social, environmental or heritage importance, for 20 years or longer" (Research Council UK, 2009 p.127)*

All electronic information was saved on my computer using my university student account. This account was password protected. The computer used during this research was also password protected and stored in a secure locked office as detailed above. All electronic files related to this research have been deleted on completion of this thesis.

All the interviews were recorded on a Tascam DR-05 Digital voice recorder. I transported the digital tape recorder safely to and from the interview venues during both phases of this research. On return to my office, the digital recordings were downloaded immediately after each interview and saved on NVivo <sup>TM</sup>. Each individual recording was then deleted immediately from the digital voice recorder. The digital recordings held in NVivo <sup>TM</sup> were deleted on completion of this study, when my thesis was submitted.

### **5.11 Quality measures in this research**

This section identifies the quality measures applied to this study. Established criteria for measuring quality in research, such as Guba and Lincoln's (2000) credibility, transferability, dependability and confirmability have been contested. This has led to rethinking of terms including validity, reliability and objectivity in relation to qualitative and quantitative research methodologies (Denzin & Lincoln, 2005). Nevertheless, Koch (1996) argues that regardless of the criterion used to determine quality, it should be consistent with the underlying philosophical assumptions on which the research is based.

Hermeneutic phenomenology, which was the research methodology chosen for this study, resides in a qualitative, interpretivist paradigm. A criticism of hermeneutic phenomenology is that it lacks validity, as knowledge is never independent of interpretation (Sandelowski, 1993; Koch, 1996). However, validity is associated with a positivist paradigm and is used to evaluate quantitative research (Liamputtong, 2009; Polit and Beck, 2010). Hermeneutic phenomenology is interpretive and does not intend to generalise. Therefore, validity is inconsistent with the ontological, epistemological and methodological assumptions of

hermeneutic phenomenology (Liamputtong, 2009; Polit & Beck, 2010a; McConnell-Henry, Chapman, & Francis, 2011). In qualitative research, trustworthiness, rigor, credibility and transferability are considered to be appropriate quality measures (Guba & Lincoln, 2000; Ajjawi & Higgs, 2007).

#### ***5.11.1 Trustworthiness, rigor and credibility***

Trustworthiness is established through demonstrating rigor and credibility in research (Guba & Lincoln, 2000). All research should be considered trustworthy, however the use of concepts for describing trustworthiness varies (Graneheim & Lundman, 2004). Demonstrating trustworthiness and rigor requires researchers to show consumers that a meticulous use of research methods occurred. Koch and Harrington (1998) suggest trustworthiness is promoted if readers can see the thoughts, actions and decisions the researcher has made and be able to audit the events, influences and actions that result in interpretive findings. The research processes undertaken for this study are discussed in depth within this thesis. There is congruence between the research methodology, research methods, data collection and data analysis, which are rationalised. This adds weight to the decisions reached by the researcher and supports trustworthiness (Maggs-Rapport, 2000), allowing readers to judge the rigor and credibility of this study (Lincoln and Guba, 2000).

One method that demonstrates trustworthiness in this study was the use of member checking which is recognised as a strategy to enhance trustworthiness (Corben, 1999; Bradbury-Jones et al., 2010). Guba and Lincoln (1989) propose that member checking is the single most reliable technique for establishing trustworthiness. The process of clarifying data against the subjects own perceptions adds to interpretations and the decisions reached by the researcher and therefore promotes trustworthiness (Maggs-Rapport, 2000). In this study, member checking occurred during each interview when, as described, clarification and probing questions were used to explore issues the participants were describing. Interview notes were taken in order to support the process of interpretation

and analysis, as well as facilitate my reflexivity during the process. Glaser (1992) supports this approach, suggesting trustworthiness is enhanced when researchers maintain written memos during data collection and analysis.

Rigor is established when research processes are visible and auditable to readers of the study (Sandelowski, 1993). However, novice researchers often find demonstrating rigor a challenge (Nolan & Smith, 2015). Researchers need to provide a documented audit trail of chosen data research methods and consistency in working within the philosophical assumptions and traditions of the research paradigm and methodology (Lincoln & Guba, 2000). My philosophical assumptions, research methodology, data collection and method of data analysis, are all congruent with hermeneutic phenomenology.

Crotty (1998) suggests that rigor is demonstrated through ensuring congruence between the philosophical assumptions and research methods. My research journal was a constant companion throughout and provided evidence of my research journey. Research journals help to promote the rigor of qualitative research (Dowling, 2006). My perceptions, experiences, preconceptions and conceptions were all documented within the journal which was used during monthly supervision sessions as an aide memoire, to show my thought processes, discussions and development of new ideas. Koch and Harrington (1998) suggest that readers should be able to recognise the activities of researcher; the cognitive process of clarifying data, involvement of external measures and the participants own perceptions throughout the research process (Maggs-Rapport, 2000).

There is a clear audit trail of monthly supervision with my research supervisors. Research supervision allowed for critical discussion and academic discourse with my research supervisors who have consistently questioned and challenged my research considerations and decisions. The research supervision sessions were summarised and recorded as supervision notes which have been submitted for research monitoring and annual progression. I was also required to meet pre-set research milestones as part of my doctoral

programme. Feedback was given following my Initial Project Approval (IPA), ethical application, annual reviews and during a third year progression panel interview. This formal record of research progression shows a sequential journey where processes and research decisions were documented.

Data collection occurred through semi-structured interviews with each participant on two occasions. There was a 12-month period between each interview and it was important to maintain contact with the participants over this time to reduce attrition. Maintaining engagement with participants over a period supports rigorous data collection (Lincoln & Guba 2000). To promote the trustworthiness of my study, individual participant quotes were used. Each individual participant interview was transcribed verbatim, directly from the digital recordings taken during both phases of this research, an example of a transcript is presented in Appendix 10. A faithful description of the phenomenon as described by participants and using their verbatim quotes allows for a rich description of their experiences and enhances the trustworthiness of research (Lincoln & Guba, 2000).

*“[Credibility] persuades readers of the research that the data is reasonably likely to be accurate and appropriate” (Denscombe, 2007 p. 297)*

### **5.11.2 Transferability**

Another criterion to measure quality in qualitative research is transferability (Hammersley, 2008). Transferability refers to the extent to which the findings can be transferred from the research sample to other settings or groups (Polit & Hungler, 1999; Lincoln & Guba 1985). As a phenomenological study this transference is limited because it was contextually constrained and the realities of the participants only related to the findings of their experiences during the period of the data collection and in context of their experiences. It was my responsibility to describe the context of this study sufficiently, so that readers are



able to judge for themselves the applicability of the findings to their own research contexts (Koch, 1996; Graneheim & Lundman, 2004).

Throughout this study, I have provided a rigorous and trustworthy account of my research processes. It is important to provide a clear and defined description of the context and culture of the research, sampling method, characteristics of participants, data collection and method of data analysis (Lincoln & Guba, 1985). For readers of this study to be able to recognise transferability, it was important that detailed ‘thick descriptions’ of the phenomenon that included descriptions, feelings, perceptions and relationships within the context of nursing, were included in this study. In Chapter 6, verbatim quotes are presented to ensure that the participant voice was heard, alongside my own interpretation of findings. Through using the participant’s verbatim quotes of their lived experiences, other researchers may discover similarities between this research and their own setting that facilitates confidence in applying the research findings within their own area of practice (Lincoln & Guba, 1985; Graneheim & Lundman, 2004). Through this process, the reader can decide if the results of this study are transferable for their own use.

## **5.12 Chapter conclusion**

In conclusion, this chapter has provided an in-depth discussion of the research methods utilised throughout this study. The sampling approach and the method of data collection have been discussed. The hermeneutic circle and a van Manen approach to data analysis have also been presented. The ethical considerations for this study have been discussed. Finally, quality measures of trustworthiness, rigor and credibility used in this study have been explained. The next chapter presents the findings of this study.

## **Chapter 6 Presentation of Findings and discussion**

### **6.1 Introduction to chapter**

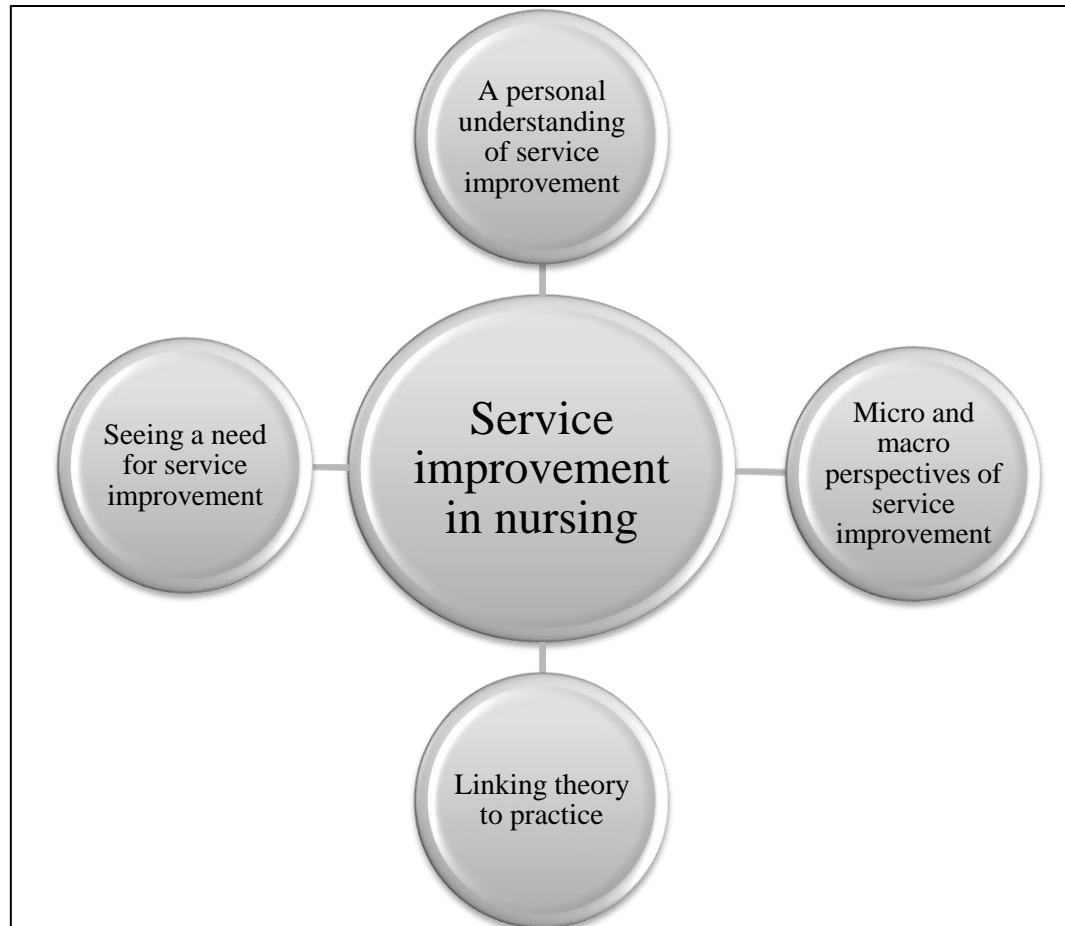
This chapter presents the findings of this study. Individual participant quotes were chosen from the data collected. The verbatim quotes used, provide rich and deep descriptions of the phenomena of service improvement in nursing as experienced by the participants. The key themes and related sub-themes are presented as; '*Service improvement in nursing; Socialisation; a sense of belonging*', '*Power and powerlessness*' and '*Challenges in changing practice*'. Each key theme is discussed using existing literature to explore its relevance and to identify new ideas emerging from the analysis. This approach to the presentation of findings is consistent with Draucker (1999) who suggests that hermeneutic phenomenology allows a flexible and creative presentation of findings whilst remaining within a sound research framework. The chapter concludes with a synopsis of the four key themes that emerged from the findings and my initial theoretical analysis.

### **6.2 Theme One: Service improvement in nursing**

Service improvement in nursing was an overarching theme that incorporates sub-themes including a personal understanding of service improvement, seeing a need for service improvement, micro and macro perspectives of service improvement and linking theory to practice. It was evident in the findings that all the participants had socially constructed an understanding of service improvement and were able to give a definition of what service improvement meant to them. The findings illustrated that the participants had experienced service improvement both in university and during their clinical practice.

Figure 19 illustrates the key theme and sub-themes that emerged from the findings:

**Figure 19 Service improvement in nursing**



### ***6.2.1 Sub-theme one: A personal understanding of service improvement***

The initial question in the interview schedule was simply asking the participants to describe what service improvement meant to them. It was evident that all the participants had a personal understanding of service improvement that they had gained during their nurse education and nursing practice.

As student nurses, the participants suggested service improvement was a mechanism through which they could enhance the patient experience through a process requiring change:

*“Service improvement to me means changing or implementing and innovating practice to improve patient care” (P8 Interview 1 Line 15)*

*“Changing any service or service that you give to patients, so it could be an intervention or some other way care is given or organised” (P 19 Interview 1 Line 13)*

*“It means trying to improve and change the service so that patients have a better experience, an overall experience” (P4 Interview 1 Line 23)*

*“I think that service improvement is engaging with the patients the service users as they are the core of health care. Its about getting their experiences and their feelings about their health care and what they feel they would like to have improved and changed” (P16 Interview 1 Line 26)*

One participant gave a description of their own personal perception of service improvement:

*“I think it is what it says on the tin. It is a way of improving service that clients and patients receive. Kind of fix something that's broken or even if it's something that not broken, making it run better. If things are difficult to do or you feel stressed, even on a ward people are running around like headless chickens, there will be a way to improve it. That's kind of my version of service improvement” (P2 Interview 1 Line 30)*

Another participant described service improvement as a fundamental goal in their clinical practice and suggested:

*“My main goal as a nurse is improving the experience for patients' good and them having a more relaxed time in hospital and they get the benefits of being in hospital and the experience is really good. So if something needs improving that will improve the service that the patients are getting, then I would have no problem in giving it a bash to see if I can get something implemented to improve the service they are getting” (P12 Interview 1 Line 26)*

The basic social construct of service improvement did not change for participants during interview two when they were registered nurses.

One participant as a registered nurse discussed service improvement as a simple continuous process, which they linked closely to improving patient care:

*“It’s [service improvement] about giving care to patients and continuously looking at the care you are giving to see if it can be improved for the patients” (P15 Interview 2 Line 41)*

Other participants described service improvement as being an integral part of their role:

*“It [service improvement] was more an organic thought” (P14 Interview 2 Line 36)*

*“I think when you reflect back you do a lot of service improvement without actually realising that you are actually going through the motions” (P15 Interview 2 Line 33)*

*“I think as a qualified nurse it [service improvement] becomes part of your everyday life” (P3 Interview 2 Line 48)*

*“I have seen changes happen on the unit that all started off as service improvement, so I see it as such a key thing now that everyone has to get involved with” (P16 Interview 2 Line 78)*

The findings in my study show that all the participants as both student and registered nurses articulated a personal concept of service improvement and were able to define it based on their learning and experiences in nursing practice. An interesting finding is that as registered nurses most of the participants described service improvement almost as an unconscious and organic process, which is integral to their role and something that they do as ‘part of their everyday life’ (P3). These findings are inconsistent with some studies which found some nurses do not recognise service improvement as a fundamental aspect to their role (World Health Organisation, 2008) and that they lacked knowledge and skills needed to make service improvements (Wilcock et al., 2009). Kovner et al., (2010) found that 39% of newly registered nurses felt poorly prepared for service improvement in practice and some nurses reported not even hearing of the concept. A plausible explanation for my findings being inconsistent is that these studies occurred before service improvement became part of pre-registration nursing curricula.

### **6.2.2 Sub-theme two: Seeing a need for service improvement**

The findings demonstrate that all the participants as student and registered nurses used their clinical practice experiences in order to identify the need for service improvements. A recurrent finding was participants seeing a need for service improvement, which they termed, as a ‘fresh eyes’.

As student nurses, participants suggested:

*“Being on placement you observe things that need to change. You have fresh eyes and so have an awareness of things that need to change and be improved”* (P18 Interview 1 Line 56)

Other participants suggested that they felt there was an advantage in being new to the clinical area as student nurses and they viewed the clinical areas ‘freshly’. These participants felt able to ‘see’ more clearly the need for service improvement than other staff who were already working in the clinical area:

*“As a student you go in and you see a lot of placements and you see a lot of ways people work, as managers and staff nurses. You go in as a fresh pair of eyes I think and you take a lot from previous placements, whether good or bad and you can bring that into your placement”* (P9 Interview 1 Line 67)

*“We go in with a fresh pair of eyes. They [the staff] just carry on and the ward will just happily run and run. Whereas we go in and say ‘this could be changed and this could be different’”* (P3 Interview 1 Line 58)

*“As a fresh pair of eyes we can sort of see things [service improvement]. They [the staff] make you feel like what is the point of bothering [with service improvement]”* (P20 Interview 1 Line 43)

*“We are a fresh pair of eyes students are, cos we have spent three years in university and we generally have fresh ideas. Whereas sometimes you go on a ward and people are stuck in their own ways and can’t see past their blinkers”* (P4 Interview 1 Line 61)

One participant seemed to value positive recognition by the ward sister, who appeared interested in the students' suggestions for service improvements,

*"The Sister wanted to know what a student's thoughts were. When a student came in from the outside and saw how that ward was run, she [sister] asked me in particular: 'You are a different set of eyes coming in. Is there anything that needs changing, what have you seen?'" (P14 Interview 1 Line 55)*

When asked how that made them feel, the participant suggested becoming empowered to make improvements through the managers' support:

*"It was good that at the end of my placement I said 'Yes there is' I don't think I would have went forward with it [service improvement] if she [ward manager] hadn't have asked and helped me" (P14 Interview 1 Line 75)*

This participant seemed to value this feedback in two ways. Firstly, their views about service improvement were valued and sought. Secondly, they appeared to be accepted into the team as a student nurse. Bradbury-Jones et al., (2007) suggested empowerment is analogous to nursing students having a voice. The concept of 'fitting in' emerged in the findings and is discussed later in this chapter, in Theme Two: Socialisation in nursing practice.

The participants as student nurses expressed a belief that they were able to contribute to service improvement. Seeing a need for service improvement through 'fresh eyes' was viewed as a positive feature in the participant's pre-registration nursing experience. These findings are consistent with Baillie et al., (2014) who found student nurses have the knowledge and skills to make a valid contribution to service improvement within their pre-registration nursing programme and feel this is important to their professional development.

During interview two, as registered nurses, several participants discussed areas for service improvements and, again, used the term ‘fresh eyes’. These participants viewed service improvement as a positive feature in their newly registered practice:

*“Looking back I think you are in the best position you just come in from university with new eyes and want to improve” (P2 Interview 2 Line 48)*

One participant expressed a similar perception which they had described during interview one, when a student nurse. This participant remained convinced that some staff did not recognise the need for service improvement:

*“I think a fresh pair of eyes is a good idea ‘cos [sic] you see things that they [staff] wouldn’t necessarily see. So it’s always good to have change” (P4 Interview 2 Line 61)*

The terminology which these participants used is noteworthy as it reflects the ‘Fresh Eyes’ toolkit (NHS Institute for Improvement and Innovation, 2015). This toolkit challenges nurses to view their clinical environment with fresh eyes and initiate service improvements rather than to continue with the same routine (NHS Institute for Innovation and Improvement, 2015). Within the findings of this study, ‘Ritual and routines’ emerged as a sub-theme and is discussed later in this chapter as part of Theme Four; Challenges in changing practice.

### ***6.2.3 Sub-theme three: Micro and macro perspective of service improvement***

As student and newly registered nurses, the participants discussed service improvement from both micro and macro perspectives.

During interview one, as student nurses, the participants described service improvements from a micro perspective.



They described small, simple changes in practice, which they perceived, were of value to patients:

*“Service improvement can be something simple and small. Like [sic] getting extra cream to add to patient cereals to increase their calories. It doesn’t have to be massive. Service improvement is on-going as well” (P2 Interview 1 Line 25)*

*“Service improvement is either for the patient it doesn't matter how small it is. Even if it just helps one patient, it’s still an improvement. It could be anything,” (P7 Interview 1 Line 27)*

*“To me it’s looking at what you have got already. So how does your service run, even on a small scale? It [service improvement] can be anything, like helping patients with filling in menus or managing meals” (P9 Interview 1 Line 41)*

These participants expressed a simple construct of service improvement. A plausible explanation of this may be linked to the participants’ experiences and beliefs that small scale or micro service improvement were seen as more achievable by them, whilst still having a positive impact on patient care. When asked about this, one participant replied:

*“Service improvement means it is where you try and get the best for the patient. you are improving the service so its best suited to them. It’s more patient-centred, small and achievable” (P 10 Interview 1 Line 56)*

Others expanded the concept of service improvement to include how service improvement may also benefit staff in terms of team working, dynamics and partnerships. These participants perceived service improvement to have dual benefits, where patients and staff may experience benefits from improvements:

*“To me it means improving things for the patient, improving their experience. Improving the overall environment that nurses are working in and the multi-disciplinary team. So when you are helping a patient, the things are better for them. It’s helping the overall dynamics of the unit. It’s just about working easier” (P16 Interview 1 Line 54)*

*“I think it means just looking at something that's not working in practice, something that can be changed for the better for the patient. For the patient primarily but also for the staff. I think it’s important not to make it with the staff first. Not just, what's good for you, it has to be for the patient. But also it can have benefits for staff as well” (P15 Interview 1 Line 24)*

As student nurses, these participants positioned the patient as being central in service improvements. These findings are consistent with Christiansen & Griffith-Evans (2010) who also found student nurses placed the patient at the centre of service improvement work. Christiansen & Griffith-Evans (2010) found student nurses understood the importance of listening to patients and service user perspectives and used this as the basis for service improvement.

During interview two, when the participants were registered nurses, service improvement was again described from a micro perspective. These participants described small service improvements, suggesting this was integral to their nursing practice and which was perceived as an almost an unconscious act:

*“It [service improvement] can be something as simple as changing to a cup with a double handle and you wouldn't even think you were improving a service. It was more an organic thought that I had” (P14 Interview 2 Line 41)*

*“We do it [service improvement] without thinking that we are, it probably comes automatically without even realising that you are doing it. I think a service improvement would come without you thinking you are improving at times” (P1 Interview 2 Line 36)*

Other participants described how they felt empowered to make small-scale improvements within the scope of their own practice:

*“I can probably say for small scale improvements, on individual patients, I often make my own decisions as to what I think might be better for that patient or what would improve their situation” (P15 Interview 2 Line 28)*

It was apparent in the findings that improving the patient experience remained a central focus for service improvement. A plausible explanation of this may be that the NHS Constitution (Great Britain. Department of Health, 2011) embeds core tenets for nursing practice including safe; effective, timely, efficient, equitable and patient-centred care (Hinds, 2013). These underpin nursing practice and endorse the concept of innovation as a mechanism to improve patient care.

A new finding emerged when participants, as registered nurses, expanded their understanding of service improvement to a macro perspective. Participants gave examples of service improvements that had developed from individual patient and staff improvements to incorporate other aspects of nursing process and practice:

*“Service improvement is what we do to improve patient care or experiences, new guidelines, procedures, little things, timing ward rounds etc.” (P19 Interview 2 Line 59)*

*“Looking back, well I have already done a small service improvement. It wasn't for patients but it was for team members, for the whole department. It was to do with a rota, it was very outdated, was not easy to use at all. We now have a better, new rota to work with” (P14 Interview 2 Line 79)*

*“We are revamping our checklists so we know a bit more about our patients. That helps the doctor and multi-disciplinary team and that way we can improve their [patient] experience” (P12 Interview 2 Line 83)*

An interesting observation is that participants as student nurses used “I” when talking about their service improvements. Once they were registered nurses, the participants used ‘we’ instead of “I”. This subtle difference in expression illustrates a change in their perception in relation to their colleagues, team and service improvements. There is a change in perception where participants felt part of the team as a registered nurse. The concept of fitting into a team and belonging emerged in the findings and is discussed later in this chapter within Theme Two.

Some participants offered further expansions on their experiences and considered service improvement within a wider context, strategically at an organisational level. These participants recognised that clinical departmental ratings and quality outcome measures were a driver for continuous service improvement:

*“It's the impact [service improvement] has on patients and their experience. For the quality outcomes, we have to improve. That reflects on the Trust” (P5 Interview 2 Line 64)*

*“We are one of the leading hospitals for cardiac care and if our service went down in the ratings then we would not be so high on that scale anymore. So I think on*

*this department that's what drives us to continually improve service” (P12 Interview 2 Line 84)*

These findings suggest that as the participants transformed from student to registered nurse they gained more experience of service improvement within their clinical area, through social interactions and expanded their understanding of the concept to include benefits to the wider area. This transformation can be considered through the lens of professional development. Benner (1982) found that as nurses move from being a novice to more competent; they become aware of aims and goals at a wider perspective. In this study, participants as registered nurses demonstrated organisational and strategic awareness of service improvement that reflected their growing political and social understanding. This wider awareness is consistent with Machin and Jones (2014) who found junior front line staff feel able to complement organisational aspirations for high quality, safe and holistic care.

#### ***6.2.4 Sub-theme four: Linking theory to practice***

Participants, both as student and registered nurses, described an awareness of different theoretical approaches and models that support service improvement in nursing.

As student nurses, participants described theoretical approaches to service improvement, which they used in their nursing practice:

*“I looked at Lewin's change theory and that was I what I used for my idea for service improvement. I had to un-freeze them [the ward staff] ‘cos [sic] they were just stuck on what the healthy eating choices are and the patients wanted more fruit. So then, I had to un-freeze their ideas and promote how important healthy eating is especially in stroke patients and patients who have Multiple Sclerosis. Then once I had sustained it I had to re-freeze it” (P17 Interview 1 Line 31)*

*“Lewin and Belbin and change theory. All of us can be change innovators or change agents. I went out and asked people some questions. So that's the doing bit. I went out and I did the study, looked at the background, created the leaflet, studied around the medications and things and I piloted it so that's the act bit” (P14 Interview 1 Line 36)*

*“PDSA it’s a model of how you go about planning and accomplishing service improvement. You are planning it, and then do it; you are studying it and the act on it. So you go through a cycle and you can also start off at different points. I looked at the planning. I had an idea of what needed doing. I made a plan and then I implemented the plan” (P15 Interview 1 Line 29)*

Kyrkjebo and Hage (2005) suggested a theory practice gap existed where student nurses were able to discuss PDSA (Deming 1986) for service improvements however; they had not heard of or seen this being used in practice. However, the participants in this study were able to describe underpinning theories including PDSA (Deming, 1986) and Lewin’s change theory (Lewin, 1951). They were able to link these theories in the application of service improvement in nursing. One participant described how it was difficult to apply theory to practice:

*“What happens in theory and practice are two totally different things. I think the constraints in practice, its OK [sic] to talk about them but then you are in practice it is hard for you to implement them” (P18 Interview 1 Line 77)*

When asked to explain what they meant, they responded:

*“People don’t want to change. In university they did mention constraints [to service improvement] money, time, people’s attitudes. So yeah, actually they did cover it when I look back. In reality it’s hard to do it” (P18 Interview 1 Line 80)*

Several participants described how they had engaged in further learning and reading, revisiting relevant literature in order to support and underpin service improvements:

*“I did a lot of reading myself and I thought ‘Yeah [sic] I do understand PDSA and I think it has been brilliant’. I was able to implement my plan; do, study and action and develop my service improvement innovation” (P14 Interview 1 Line 57)*

*“You go and look back at the literature base behind the improvement. I had done it and I had failed. But looking back, I know the literature around why it failed and I know how to do it in future so that it works. Your understanding of change and leadership styles and service improvement theory changes so that you would perhaps use it differently next time so you can get your service improvement through” (Participant 7 Interview 1 Line 53)*

These findings are consistent with other studies that have reported that student nurses understand service improvement tools, including PDSA and that students found them to be

beneficial in practice (Christiansen & Griffith-Evans, 2010; Jones et al., 2013; Smith et al., 2014).

This may be an important finding as these studies have occurred since service improvement has been incorporated into pre-registration nursing programmes (NMC, 2010). This may reflect coherence between theoretical and practice service improvement components of pre-registration nursing programmes. This approach of curriculum coherence bridges the theory practice gap and enables student nurses to understand the connection between educational theory and the practice of nursing (Hatlevik, 2012). A consistent finding that emerged during interview two, when participants were registered nurses, was how they had integrated service improvement theory into their on-going professional learning and experience in clinical practice, suggesting developing confidence in linking theory to practice:

*“I am still learning, but if you have a good idea about something, having the confidence to go with it and give your reasons and rationale as to how and why you want to do in order it to improve the patients service is something I know I can do. I can use PDSA [Plan, Do, Study, Act] as a guide to help me” (P15 Interview 2 Line 94)*

*“I think you gain knowledge and skills as your career progresses. You don't want to go in with a huge service improvement plan, just start little and build up. I have used some of the theory about change and PDSA [Plan, Do, Study, Act]. I am always reflecting and learning” (P6 Interview 2 Line 86)*

Several participants described additional learning about service improvement which they experienced as part of an in-house NHS Trust education and preceptorship programme during their newly registered period:

*“As part of preceptorship I have done it [service improvement]. We had a day on service improvement and during the preceptor period, we have the knowledge and skills framework, which we have to work towards, and this increases my knowledge of it. Without learning, you would never be getting to where it is best practice. I think if you don't look for how you can improve your service. You don't get better at anything. You don't improve things for your patients at all” (P 2 Interview 2 Line 62)*

*“I have gone to training sessions in my preceptorship. I have been able to bring things about it [service improvement] back. I have thought there are things that are relevant, or if people were not aware of them, I have been able to bring them back. People have been really receptive to implement them” (P11 Interview 2 Line 70)*

These participants described the preceptorship programme, which augmented their previous service improvement learning. It appears these participants saw this programme as beneficial in helping them make service improvements in practice. These findings reflect other research which has found that nurse-led service improvement requires knowledge and skills that must be practiced and refined in order to be successful (Wilcock & Carr, 2001; Christiansen & Griffith-Evans, 2010).

One participant reflected on their previous learning of service improvement and identified being aware of a need to revisit the theory relation to undertaking service improvement in future:

*“If I was to set out and do some service improvement, I would look back at the theories behind it. I would have a good read and re-educate myself” (P15 Interview 2 Line 40)*

These findings reflect Lynn et al., (2007) who found healthcare staff evaluate their previous experiences of service improvement in order to identify and implement future service changes.

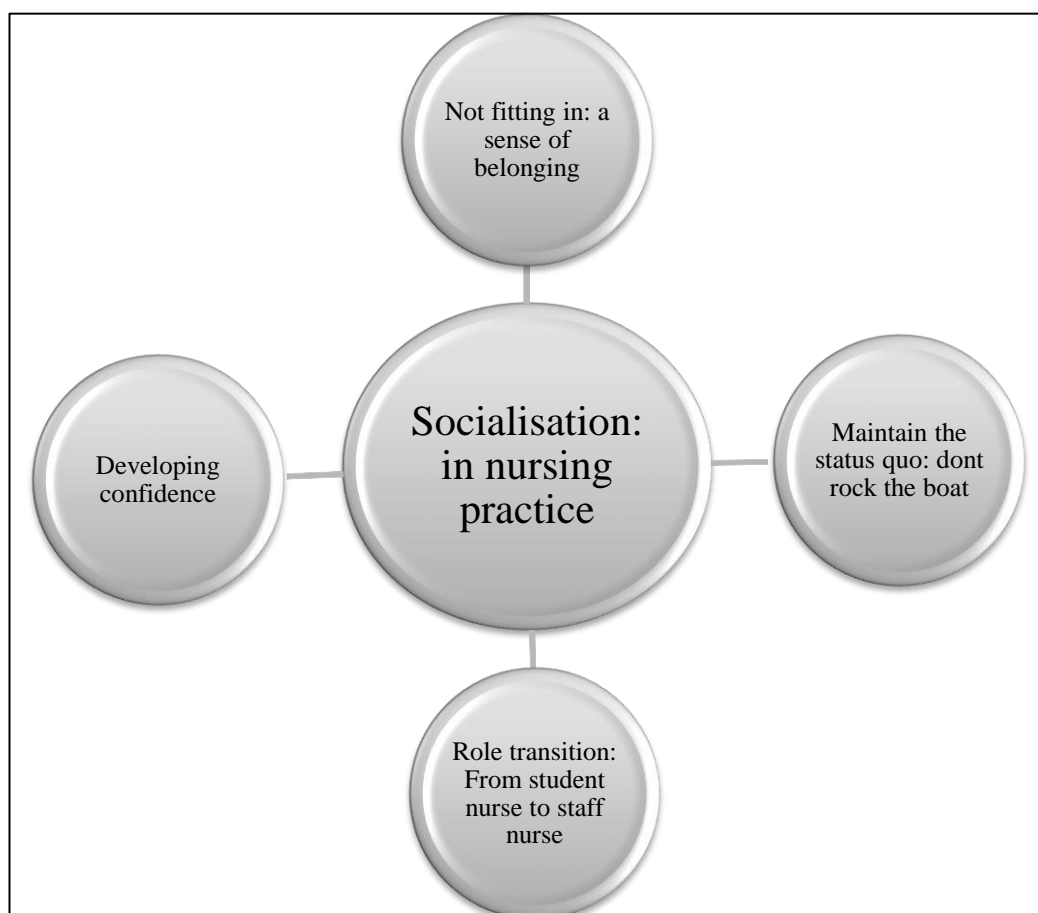
#### ***6.2.5 Summary of Theme One: Service improvement in nursing***

Service improvement in nursing demonstrated how all the participants had increased their knowledge and experience of service improvement as they transformed from student to registered nurse. The participants demonstrated an understanding of the theoretical models and approaches to service improvement, which was sustained throughout their transformation from student to registered nurse. The participants as registered nurses demonstrated a process of professional transformation through their ongoing education and practice experiences in making service improvements in nursing.

### 6.3 Theme Two: Socialisation in nursing practice

It was apparent that socialisation and learning in nursing practice was an important feature for participants as both student and registered nurses. Socialisation is the process which starts during nurse education and continues throughout a nurses career (Dinmohammadi et al., 2013; Kay, 2015; Strouse & Nickerson, 2016). Socialisation in nursing, occurs through social interactions with colleagues in clinical practice and can have both positive and negative consequences concerning the development of the nurses (Gray & Smith, 1999; Mackintosh, 2006; Kay, 2015). Figure 20 illustrates, ‘Socialisation: in nursing practice’ and four emerging sub-themes:

**Figure 20 Socialisation in nursing practice**





### **6.3.1 Sub-theme one: Not fitting in; a sense of belonging**

The concept of ‘fitting in’ to the clinical area was a consistent finding which emerged for participants when they were both student and registered nurses.

During interview one, some participants as student nurses described feeling they did not fit into the clinical team during their nursing practice. These participants described how fitting in depended on whether they felt included or excluded by their work colleagues:

*“It’s hard when you are in practice, you don’t seem to have a role. You are there as a student nurse and to learn, but not really. You are there only 8 weeks; you are not really taken on as part of the team” (P10 Interview 1 Line 69)*

*“As a student I think it is difficult to fit in” (P20 Interview 1 Line 41)*

*“I’ve seen it on different wards. You don’t feel you belong. It doesn’t matter what you do. You have to just learn to fit in. I felt not supported” (P 7 Interview 1 Line 72)*

*“It’s quite hard for student nurses, you never feel you belong, especially on the ward I was on. I would ask the people politely if they wanted help. A lot of the time I would help them out, but I was just ignored” (P10 Interview 1 Line 38)*

These findings are consistent with other studies, which found many student nurses experienced feelings of not fitting in or belonging to the ward (Gray and Smith, 1999; Levett-Jones et al., 2009a; Bradbury-Jones et al., 2011; Feng & Tsai 2012; Thomas et al., 2012). A lack of a sense of belonging can lead to negative consequences for student nurses such as reduced self-esteem, self-defeatism and psychological distress (Levett-Jones et al., 2009b). Chesser-Smyth and Long (2013) and O’Mara et al., (2014) found personal relationships with clinical staff was a significant source of anxiety, stress and vulnerability in students nurses in practice. If the social needs of student nurses are not met this can influence how they cope with the demands of their education (Freitas & Leonard, 2011).

Other participants described similar experiences of not fitting in and attributed this to having a direct impact on their ability to make service improvements:

*“I went into it thinking I can’t do it’ [service improvement]. I’m not a member of the team and I am not fully involved in it” (P7 Interview 1 Line 27)*

*“I think when you are a student on a ward, even though you have a valid point to make, they just ignore you because you are a student” (P18 Interview 1 Line 119)*

*“I think that everybody puts a barrier up for a student nurse going into the ward and you have to be liked or that barrier stays there for 8 weeks or for as long as you are there. The don’t help you do your improvement’s” (P6 Interview 1 Line 71)*

*“There are some people who would just brush you off [sic] and not listen to you. Sometimes I think it’s like ‘well I should have thought of that, so I am not going to give the student that’. Sort of keeping us [students] down” (P 13 Interview 1 Line 41)*

These findings highlight that those participants who had negative experiences of fitting in were less able to make service improvements. These findings are consistent with other studies which identified disempowering situations for student nurses, where their lower status led to non-acceptance and resistance to their suggestions for change (Daiki, 2004; Levett-Jones et al., 2009b; Johnson et al., 2010; Baillie et al., 2014). The student nurses were often marginalised, isolated, ignored or faced indifference in their clinical placements (Levett-Jones et al., 2009a; Levett-Jones et al., 2009b; Bradbury-Jones et al., 2011; O’Mara et al., 2014).

Levett-Jones et al., (2009a, 2009b) found student nurses felt part of the team when staff interacted informally with them on the wards and during meal breaks. Positive socialisation and the desire to fit in and belong were cited by student nurses as being more valuable than the type of nursing experience they had (Levett-Jones & Lathlean, 2008). A plausible explanation for the findings in this study may be a reflection on the mentors and staff with whom the participants were working. Kay (2015) found that mentors who were not supported during their own social development in nursing, are less effective in supporting the professional socialisation of others.

One participant described a particularly difficult experience of not fitting into the team. They stated they tried to join in conversation at lunch times and develop relationships with their work colleagues but were ignored:

*“There were a few people who let's say I had put their nose out. They did not like the idea of me coming in as an outsider and changing bits...erm [sic] sometimes it would be a bit hard. You don't fit in. You would go to lunch and try and join the conversation and they would like [sic] blank you a little bit” (P13 Interview 1 Line 105)*

P13 described being ostracised by work colleagues following their attempts at making a service improvement. When asked how this made them feel, they replied:

*“It made me feel sort of not worth much really [sic], that they just didn't care about me, or how I felt” (P13 Interview 1 Line 115)*

The interview notes taken at the time of the interview illustrate this participant shrugged their shoulders at this point, suggesting ‘shrugging’ off this experience and developing resilience.

Several participants described strategies to help them fit in such as assisting colleagues and working hard on placement. These participants described using non-threatening approaches in order to develop relationships and fit in, suggesting developing resilience:

*“I've kind of made an approach which is what I'm going to do with my new placement, I'm going to start in and tell them I've never been on here erm [sic]. When I settle in at first and my initial interview kind of thing and then I will be friendly and just learn. I kind of process it in my head for a couple of weeks and think' oh how do I fit in here?' I usually pull my weight and work hard” (P7 Interview 1 Line 148)*

*“As a student you are only there for eight weeks, the first three weeks are just getting used to the ward. I just go in and say can I help here? ” (P8 Interview 1 Line 97)*

P 7 went on to suggest that other student nurses used a similar approach:

*“I was quite lucky, there were 3 students and we all chatted about assignments and we all said we have to look at service improvement, and we sort of brought it around that way instead. Rather than going and saying ‘I have to implement this.’”*  
(P7 Interview 1 Line 87)

These findings are consistent with studies which found student nurses work in order to ‘fit in’ (Melia, 1982), are willing to ‘learn the routine’ and ‘muck in’ as strategies to gain acceptance by ward staff and develop skills necessary for professional practice (Gray and Smith, 1999; Maben et al, 2006; Thomas et al., 2012; Houghton, 2014).

One participant suggested their age (22yrs) was a factor in not fitting in; work colleagues were older and perhaps had less in common with them as a younger student. This participant described how their confidence was at risk because of this experience:

*“I find it quite difficult to fit in. I came into the NHS straight from leaving six form and I didn't work with any younger staff nurses they were all older and very experienced. I found it difficult to go in and say this is what I want to change. I gained a bit more confidence but I think if somebody had challenged me I think my confidence could very easily have been shattered”* (P9 Interview 1 Line 62)

Factors such as fear and shyness are recognised as obstacles for younger nursing students (Stewart, Mort, & McVeigh, 2001). The emotional response to stress in younger nurses is greater than more mature peers and students with low levels of resilience have less ability to cope with stress (Munro, Bore, & Powis, 2008). When probed further, this participant went on to discuss how, over time, they had gained confidence; they appeared to have developed resilience:

*“I just got on with it [service improvement]; I got a bit more confident. Sometimes you can't please everyone; you just have to get on with things”* (P9 Interview 1 Line 102)

One participant suggested fitting in and being respected by the team was a feature of student nurse practice experiences, but felt that they did not have to feel they fitted in:

*“I don’t have to fit in. I’ve hit the age now where in my 30’s where I think ‘it doesn’t really matter you can call me what you like’. It’s not going to affect me or affect my life. But I think if you are a little bit younger, it might be difficult to say ‘I don’t care what you think. It’s my opinion and I am entitled to it’” (P 3 Interview 1 Line 67)*

This statement was checked for understanding by asking, ‘do you think age is important?

The participant replied:

*“For me personally it’s my age and having had a working career for a long time. You have to stick up for yourself” (P 3 Interview 1 Line 71)*

A plausible explanation for this finding in my study may be this participant was a mature student (P 3 aged 32), with previous life and work experience as a HCA that helped them to adapt and feel less pressured to fit in the team. Previous caring experiences is one explanation for greater confidence in mature students and this affects their emotional responses (Evans & Kelly, 2004). In addition, older nursing students have higher levels of resilience than younger students (Pitt, Powis, Levett-Jones, & Hunter, 2014).

An interesting finding in this research was that as student nurses, participants did not challenge their perceptions of not fitting in and accepted this experience as part of being a student nurse. This finding is consistent with Nixon (2014) who found student nurses had difficulty in being frank about negative experiences in clinical practice. O’Mara et al., (2014) found student nurses retreat from the challenge of socialisation as a coping strategy. In this study, those participants who did not fit in simply acknowledged this was the case and recognised it as a common phenomenon that student nurses experience and which they had little control over. My findings provide evidence that the participants were describing a developing resilience. Stephens (2013) found that student nurses develop resilience by using a variety of personal protective factors to successfully navigate stress and difficulties.

O'Mara et al., (2014) found that student nurses will 'reframe' negative experiences by working to build relationships and seeking support from other students and staff. Through 'reframing' students were shown to become more self-reliant and independent (O'Mara et al., 2014).

In contrast to these experiences, other participants felt that they were accepted within the team as student nurses and this acceptance had played a part in them being able to make service improvements. These participants seemed to value their experiences, reflecting how colleagues who supported them, helped them make to service improvements:

*"I found I fitted in more than in any other placement. They wanted to know what a student's thoughts where. I just got on and did it [service improvement]. I think she (ward manager) was just brilliant, she respected student nurses and you do not often get that." (P14 Interview 1 Line 71)*

*"It was positive. I had good support from the team that actually helped me to do it [service improvement]" (P11 Interview 1 Line 56)*

When P 11 was asked more about how they felt fitting in the team had helped them make their service improvement a success, they replied:

*"I think from doing the project [service improvement] with them I was able to build my confidence. Like [sic] maybe more voicing my ideas and that, cos [sic] I had never really done anything before like that in practice. I think building my confidence was obviously good as well, but like[sic]to collaborate with others. Obviously you do all the time when you are working but doing something like that [service improvement] and building my confidence to collaborate with people to develop ideas for change" (P11 Interview 1 Line 60)*

This finding suggests that P11 was developing confidence to voice their opinions, despite not having made service improvement suggestions before and that they were developing resilience through their experiences. Jackson, Firtko & Edenborough (2007) found positive mentoring relationships, personal growth and professional reflection are strategies that help student nurses develop resilience.

During interview two, as registered nurses, the participants' perceptions changed to where they felt that they fitted in to their teams and described being valued. These participants reflected back on their student experiences and made a direct comparison to their experiences as registered nurses:

*"I think when I look back to when I was a student I don't think I was ever really part of the team. Compared to now, I didn't belong"* (P8 Interview 2 Line 29)

*"As a student you weren't embedded in a culture or in a team quite as much. I know you were an outsider with outside views which is sometimes good, but I think when you are working in it all the time I think it is easier to pick up the things that need a little bit of help"* (P2 Interview 2 Line 49)

*"As a student you don't have the confidence to implement anything, I guess it's how well you get on in the team but obviously you move from placement to placement all the time, so that makes it really difficult. As a qualified and a good member of the team, you get on well with everyone. You fit in and you wouldn't be afraid to say to someone; 'maybe we can do it this way?'"* (P5 Interview 2 Line 75)

The findings in this study reflect Carlin (2013) and Luanaigh (2015) who found that newly registered nurses benefit from a sense of belonging and this forms an important aspect of their professional development. Other participants expanded on fitting in and described how they developed personal relationships with colleagues they worked with and this was a feature in helping them develop a sense belonging as part of the team:

*"I think the longer you work somewhere you just get settled and become part of the team"* (P4 Interview 2 Line 61)

*"As a qualified, you become a good member of the team; you get on well with everyone"* (P5 Interview 2 Line 27)

*"I think I enjoy being part of a team, you get to chat more, people are more honest with you"* (P10 Interview 2 Line 83)

These participants appear to value the relationships they had developed with colleagues suggesting they felt settled and enjoyed being part of the team. These findings are consistent with Putnam (1993) who found work relationships, which develop over time, improve feelings of self-esteem and can increase success.

Feng and Tsai (2012) found that newly registered nurses go through a process of socialisation where they build interpersonal relationships with colleagues, acquaint themselves with the ward rules and culture and become part of the team. Expanding on this, P1 suggested:

*“It’s a good team I work with and we know how things work well. I think we are just such a good team. We work well together, we listen to what anyone else says and we just get on and do it [service improvement]” (P1 Interview 2 Line 80)*

This finding supports Rytterstrom et al., (2011) who found newly registered nurses adapt to the ward routine and this makes it easier for to be accepted by staff on the ward.

As registered nurses, the participants described skills that they had developed and utilised during their experiences in service improvement. Effective communication skills were a key feature in fitting in with colleagues and how these participants made suggestions for service improvements:

*“Good communication skills, to be diplomatic, to be able to be open minded and see other people’s points of view. Listening to what people say to you” (P15 Interview 2 Line 53).*

*“Communication skills, just negotiating. I think coming to university just gave me more confidence to talk and fit in” (P14 Interview 2 Line 78)*

*“We listen to what anyone else says and we just get on and do it [service improvement]” (P1 Interview 2 Line 84)*

These findings reveal the participants value working in teams where they have opportunities to discuss suggestions for service improvement in a supportive team. Dinmohammadi et al., (2013) found professional socialisation involves supported clinical experiences and opportunities for constructive feedback. Positive socialisation has been seen as having a critical role in integrating new nurses, enhancing their commitment to the organisation and improving skill acquisition (Tomietto et al., 2014).



### **6.3.2 Sub-theme two: Maintain the status quo; don't rock the boat**

During interview one as student nurses, some participants expressed concerns about suggesting a need for and making service improvements. These participants felt that if they identified a need for service improvement, it might be perceived in a negative way by the ward staff. This perception was linked to then being seen as an unpopular student and this fear made them cautious about introducing the concept of service improvement:

*"I'm the type of person who likes to get on with people so I didn't want to ruffle anyone's feathers. So I wasn't really keen to put the [service] improvement into place" (P7 Interview 1 Line 47)*

*"I am just going to upset them [the ward staff] if I say that [service improvement] is needed or if they think the ward is not up to it or they are doing something wrong. Then that might be awkward" (P16 Interview 1 Line 57)*

These findings reflect Nixon (2014) who found many student nurses choose not to challenge their experiences in nursing, as they do not want to be seen as troublemakers. The finding in this study suggests the participants' acceptance and reluctance to challenge how they were socialised, may be a response to not wanting to compromise their uncertain sense of belonging. The participants were third year student nurses, applying for jobs the local NHS Trust. Nixon (2014) found that student nurses are fearful that negative feedback from clinical placements may affect their future job prospects.

One participant described how their primary aim was to complete their placement successfully and did not want to risk this by suggesting ideas for service improvement:

*"I just want to do my placement I don't want to rock the boat; I just want to get to the end and pass" (P20 Interview 1 Line 37)*

Other participants described feeling vulnerable as student nurses and did not want to be perceived as challenging or difficult. Participants wanted to maintain a feeling of stability, to fit in and get to the end of the placement without conflict or challenge.

They described the ways in which they had adapted their approach to service improvement and had introduced the concept to work colleagues in an incremental way, making their suggestions for service improvement appear informal:

*“I didn't really want to say anything when I first started and then a couple of weeks, after I had settled in, I thought I am going to have to say something. I really needed to get it [service improvement] done. I was a bit scared really, to be honest, to try and start the conversation off, I did it like [sic] informally. I sort of had the feeling that they would probably bring up some barriers to it, which a few of them did”* (P15 Interview 1 Line 65)

*“Yeah, I'd say it more casually, like not just saying ‘do you know what you should do on this ward?’ or ‘this would be better’, just casually saying.... ‘do you think there's problems? [sic] Obviously, we have to do a project; you can't when you are a staff nurse. Maybe just saying I haven't been here very long, have you got problems with this... you know...just informally chatting.”* (P1 Interview 1 Line 107)

*“I think it's difficult being a student and you always feel not as confident. You have to be gentle to get there with the knowledge that underpins it [service improvement] and be savvy [sic] how you suggest it”* (P20 Interview 1 Line 105)

These participants introduced service improvement through ‘casual conversation’ and were shrewd in their delivery. These findings reflect Gollop et al., (2004) who found that student nurses gain engagement in service improvement through finding either an overt or covert ‘hook’ with which to gain interest. Levett-Jones and Lathlean (2008) and Levett-Jones et al., (2009a) discovered that when students fitted in and had a sense of belonging, they developed communication strategies which enhanced their learning. Participants adopted communication strategies that they felt would be more acceptable and provide less risk to their position as a student nurse (Levett-Jones et al., 2009a).

The perception of ‘maintaining the status quo’ did not feature in the findings when the participants became registered nurses. During interview two, participants recognised that by suggesting or making service improvements they might encounter resistance to change.

Despite this, these participants stated they would pursue service improvements, further suggesting that they were developing resilience:

*“I have probably just grown maybe a little since I was a student. It doesn’t bother me now. I would just do it [service improvement]” (P16 Interview 2 Line 93)*

*“You will never get everybody on board. Someone will always find a fault and you can’t please everybody. I think that’s one of the things I have found from being registered is that you can’t please everyone. You just have to get on with it [service improvement]” (P6 Interview 2 Line 107)*

As registered nurses, the participants were not prepared to accept existing practice and ignore areas for service improvement.

*“It’s not becoming complacent with care, if you don’t do service improvement you are not improving the care you are giving. You become complacent with the care; you are not questioning why you are doing things and how you can better it” (P10 Interview 2 Line 92)*

*“When qualified you do have a say and it’s important that I do speak up and do have a say in things” (P19 Interview 2 Line 85)*

*“You can now see where the flaws are and you can say well I’m not happy with this. Maybe we can change it. I want to keep my practice to the right way so they [ward staff] are in a way resisting the change ‘cos [sic] they have always done it that way” (P2 Interview 2 Line 41)*

These findings are in contrast to Maben et al., (2006) who suggested that newly registered nurses kept quiet rather than ‘rock the boat’ in their initial post-qualifying period and this prevented them from influencing and changing practice. A plausible explanation of the findings in this study may be the adoption of characteristics fundamental to nursing practice. Integral to nursing is the 6C’s which include care, compassion, competence, communication, courage and commitment (Hardacre, 2014). It was apparent in the findings of this study that the participants were determined not to accept the status quo, suggesting they were developing resilience. Resilience, is reflected through an individual’s sense of self-determination (Hart et al., 2014). In this study, the participants were willing to face challenges and resistance to change in order to be successful in making improvements.

Resilience is how individuals recover from setbacks in order to cope successfully despite often-adverse circumstances (Dyer & McGuinness, 1996; Hart, Brannan, & De Chesnay, 2014).

### **6.3.3 Sub-theme three: Role transition from student nurse to staff nurse**

Several participants as student nurses discussed third year of pre-registration was an appropriate stage in their pre-registration programme to undertake service improvement in clinical practice:

*“I wouldn’t have liked to have had to do this [service improvement] before third year. Definitely not”* (P11 Interview 1 Line 89)

*“I think that in third year I feel more comfortable in challenging practices and procedures”* (P2 Interview 1 Line 91)

*“At this stage when you about to qualify you need to be able to go and be involved in it [service improvement] when you qualify”* (P16 Interview 1 Line 101)

Other participants expanded on this and rationalised why they felt that third year of their programme was an appropriate stage to implement service improvement in practice. These participants believed that by the third year of their programme they had obtained the necessary skills to make improvements:

*“I think it is appropriate as a third year because of the time, confidence and knowledge it takes to do the service improvement”* (P4 Interview 1 Line 93)

*“As a student we have only really being doing that [service improvement] for the last few months. Talking about changing practice and that. The first couple of years were spent learning how to do things. It was all new but whereas now it’s like ‘well what you would do differently?’”* (P8 Interview 1 Line 55)

*“I think being a third year you are looked at totally different and I think that now when you go on placement and you walk on and they find out you are a third year student there’s an expectation that you have the knowledge but I think it’s about going in and understanding my limitations. I can’t go in and change NHS policy, but I could go in and change, personally without anyone, something simple like cream on porridge. And it’s about me acknowledging my limitations as a student and I would go and get help to try and change things”* (P3 Interview 1 Line 37)

A plausible explanation of this is that the participants needed time during their first two years' education to understand and develop clinical practice and other nursing skills before concentrating on service improvement. This view is consistent with Vygotsky's ZPD (1978) where, as learners become accomplished in skills, they no longer need teacher support. As student nurses near nurse registration, they begin to distance themselves from their mentors and move from tasks to be learnt to thinking more holistically and independently (Gray & Smith, 1999). Several participants discussed a perception that ward staff recognised their growing knowledge base and experience as a third year student nurse:

*"I think staff respect you more in third year, looking back I think that in first and second year they (ward staff) kind of don't listen to you as much but in third year when you are nearly qualified they respect you a bit more and are more likely to listen to you" (P17 Interview 1 Line 92)*

*"Maybe they (ward staff) don't think that students have got the experience or the knowledge. It depends on what stage the training is as at, but as a third year you might have a bit more understanding. But some people still just see students as a student (P3 Interview 1 Line 107)*

However, during interview two, participants described role transition from student to registered nurse and how this was a challenging time for them, particularly when attempting to make service improvements:

*"From a personal point, nothing prepares you for that first day in a staff nurse uniform. That is no disrespect to the training, but it just doesn't prepare you at all. You have to realise you step from student to staff nurse and it's a huge difference, but I don't think you realise until you do it" (P19 Interview 2 Line 93)*

*"I have just tried to stay afloat basically, completely, actually...totally just trying to stay afloat. To be totally honest some days it's like. Eeeek [sic] get me out of here and some days it has been alright" (P1 Interview 2 Line 87)*

These findings support other studies that found that newly registered nurses found role transition traumatic (Kelly, 1996; Duchscher, 2009; Feng & Tsai, 2012; Hatlevik, 2012). Some participants explained that being involved with service improvements as registered nurses was challenging due to the pressures they faced during role transition.

These participants described the rapid rate of learning their new role, conflicting priorities including a lack of knowledge and skills, difficulty in time management and having to juggle prioritising patient care over other tasks and stress:

*“I feel as if I have found it really difficult being in the numbers. I am still quite new to this [service improvement] I am so busy concentrating on my job. I have so much to learn. It’s when you are working with a patient you do it every day, it’s how you can improve the service for the patient for that day and what will improve their care” (P10 Interview 2 Line 58)*

*“Working on the ward and trying to do service improvement, you just don’t have the time. You don’t have the time to do much more important things. Not that service improvement isn’t important, but you struggle to cope with your day to day tasks without adding to it” (P6 Interview 2 Line 80)*

These findings are consistent with Kelly (1996) who found that newly registered nurses suffer overwhelming stress in living up to their individual perceptions of the role of being a nurse and that this was related to the influence of socialisation and self-expectations. Studies have shown that newly registered nurses encounter a gap between knowledge acquired in nursing education and the competing demands in clinical practice (Feng & Tsai, 2012; Hatlevik, 2012). Participant 15 suggested that they had not thought about service improvement consciously as they were preoccupied in learning how to be a registered nurse:

*“I don’t think you think about it [service improvement] consciously especially as a newly qualified nurse. Certainly nothing major, maybe little things for a patient, maybe for individual patients but not big patient scale. You are so busy trying to get your head around what it is being a staff nurse” (P15 Interview 2 Line 46)*

When I asked for clarification on their service improvement experiences, they went on to describe a small scale improvement which they were able to manage:

*“I have done [sic] a real small scale one with some of my diabetic patients. A few weeks ago I was thinking, we have 6 diabetic patients so you tend to get into the routine of just doing what's told on the prescription and doing their blood sugars. So I went back to each of the blood sugar readings and re-evaluated how often we needed to do their blood sugar readings. It is not good for the patient having to prick their fingers every single day. One of the ladies had been up and down with her readings, but we managed to get her stable with her blood sugars and we were still doing her blood sugars every single day. So I re-evaluated it and went to the sister and said could we maybe do it Monday, Wednesday and Friday? for her blood sugars as she is stable So that was small scale but I think it was better for the patient not having to pick their fingers every day and I have done that for a few of the patients now.” (P15 Interview 2 Line 50)*

Several participants appeared to be frustrated at the challenges in making improvement during role transition. P3 she described feeling impotent to ‘do the little things that are important’ and ‘struggle to cope with every day tasks’. My interview notes recorded she shook her head as she stated:

*“It is hard, very hard. You have many pressures as a registrant. As an almost qualified student, you had more time to focus on the little things that obviously matter. Whereas when you are qualified, those little things are the things that get left behind and don't get done because you have to focus on the essentials. Finding the time is the hardest. I didn't expect to be pulled in so many directions and have so much prioritising and so much work ahead of service improvement and ahead of making the changes for little things that are so important” (P3 Interview 2 Line 115)*

Another participant suggested that:

*“You realise ' Oh if I could do this better, I could do this', but its hard cos [sic] you can't always get it done” (P8 Interview 2 Line 93)*

These findings correspond with Feng and Tsai (2012) who suggest that some registered nurses found role transition challenging and consequently this made them feel frustrated. Despite some participant descriptions of challenging experiences of service improvements during role transition, others discussed experiences that were more positive.

Several participants acknowledged their learning and development through role transition to registered nurse was on a trajectory:

*“As I am getting further on [as a registered nurse] I am more confident and more settled in my role” (P12 Interview 2 Line 96)*

*“Oh, there’s loads to do. I am still learning, but that [knowledge and skills] will come over time” (P8 Interview 2 Line 103).*

One participant explained how they needed some time to settle into their new role as a registered nurse, but once they were established in the team, they were able to contribute positively to service improvement:

*“I think it [service improvement] is easier as a newly qualified after a few months. I think you can’t go straight in and say we should change this and change that. I think once you have settled into your role people appreciate that you have taken this period of time to take it all in and to acclimatise to how they work. I think if you then go to them and say “I think we should do this differently”, they say “Oh, OK”. Once you have settled in and you are over the whole systems shock you are able to see it all as a bigger picture and fit it all in” (P2 Interview 2 Line 78)*

Some participants discussed how they perceived a difference between being a student and registered nurse and described service improvement as a fundamental aspect of their role as a nurse:

*“As a qualified nurse, you are more responsible to look at things to be improved and make sure your service is better for patients” (P12 Interview 2 Line 109).*

*“I think as a qualified nurse it [service improvement] becomes part of your everyday life. As a student you would flit in and out, you would go “Oh, they are starting this project, I will research why” But you could not follow it through. As a qualified [nurse], if you see something that needs to be altered or changed to improve things for patient’s care, nobody else will do it for you, ‘cos [sic] you are a qualified nurse” (P3 Interview 2 Line 55)*

*“Oh its much easier being qualified giving your [service improvement] ideas” (P8 Interview 2 Line 46).*

Other participants identified the local NHS Trust preceptorship programme as a supportive mechanism, which helped them during role transition and in making service improvements.



The preceptorship programme seemed to be valued by these participants, who enjoyed the experience and found it beneficial to their service improvement practice:

*“I have two supervisors for my supernumerary time and preceptorship period. I had continuity and I got to work with everybody and was introduced to the whole team. I settled in really quickly and have really enjoyed it. It [preceptor programme] helped me with confidence to make improvements to patient care”* (P16 Interview 2 Line 75)

*“The preceptorship course that the hospital runs have a lot of education. Part of my preceptorship went [sic] into service improvement. That helped me a lot”* (P2 Interview 2 Line 69)

These findings are consistent with Feng and Tsai (2012) who found newly registered nurses are willing to spend time to developing their knowledge, learning new skills and increasing their experiences in order to fulfil their role. Dinmohammadi et al., (2013) found essential features for effective professional socialisation include comprehensive educational programmes.

#### **6.3.4 Sub-theme four: Developing confidence**

Participants, as both student and registered nurses, discussed confidence as a characteristic they recognised in relation to making service improvements in nursing.

During interview one as student nurses, some participants described a lack of confidence in making service improvements. These participants described how the attitude of some colleagues and mentors had an impact on their self-belief in making improvements:

*“I expressed that I didn't have the confidence to approach the matron and people like that to get it [service improvement] implemented and they [work colleagues] just didn't seem that interested”* (P12 Interview 1 Line 58)

*“I had some knowledge about it [service improvement] but it was just having the confidence to tell them [work colleagues] and do it”* (P16 Interview 1 Line 82)

*“It's about being confident to go ahead and do it [service improvement]. I didn't really have any [confidence] and struggled in telling my mentor”* (P17 Interview 1 Line 91)

These comments reflect Chesser-Smyth and Long (2013) who found that low levels of self-confidence can be eroded further by poor mentor attitudes, a lack of communication and feeling not valued. Nevertheless, in this study, the majority of participants as student nurses described how they began to develop confidence in service improvements, acquiring personal characteristics that they linked to their leadership skills:

*“Having confidence, passion, motivated to do it [service improvement]. Leadership skills, you need to be able to explain what you want to do and fight your corner. I think that's all really. Yeah it's about being confident”* (P17 Interview 1 Line 68)

*“I think you have to be confident in yourself, so if you believe that something should be changed, then you must have the confidence to go out there on your own if necessary. I think if you really believe in it and are motivated. You have to have the confidence to go out and do it [service improvement] and I think it's probably the leadership sort of aspect of nursing”* (P15 Interview 1 Line 100)

*“My mentor was really motivated to help me; she was very open to it [service improvement] and helped me to develop confidence. I had good support that actually helped me to do it”* (P11 Interview 1 Line 63)

These findings reflect how self-confidence is the belief in the nurse's ability to accomplish a task competently and effectively (Crooks et al., 2005).

An important finding which emerged during interview two, saw the participants as registered nurses, describe becoming more confident in their ability to suggest and make service improvements:

*“I have become a bit [sic] more confident in the role as a staff nurse. It is not easy by a long way being confident in your ideas and rationalising that it is going to improve the service. Getting it across to staff members that it is going to improve things and that's what we are here for”* (P12 Interview 2 Line 96)

*“I am just more confident or more comfortable with it 'cos [sic] I work here and I am in the environment where you have to put things forward to improve”* (P16 Interview 2 Line 49)

These participants articulated gaining confidence through their on-going education, and experience, suggesting they were becoming empowered to make service improvements:

*“If you have a good idea about something, having the confidence to go with it and give your reasons and rationale as to why you want to do it and if it’s to improve the patients service, then I think you work on it” (P4 Interview 2 Line 96)*

*“I have a degree and more confidence and those things combined and a responsible position. I have the confidence to be able to lead things and say this needs to change” (P14 Interview 2 Line 51)*

*“I have trained a bit more now. I have the skills, confidence and leadership to lead and run a team. I can make the improvements” (P11 Interview 2 Line 76)*

It was evident that the participants developed self-confidence in relation to their ongoing professional development, increased responsibility and leadership skills. Feng and Tsai (2012) discovered that learning new skills and knowledge is challenging for newly registered nurses; however, they persevere because this helps them build confidence in improving patient care. My findings provide evidence that the participants were becoming empowered in making service improvements. Crook et al., (2005) found that growing confidence reinforces a nurse’s competence in effective care delivery and this is closely linked to empowerment and self-efficacy.

#### ***6.3.5 Summary of Theme Two: Socialisation in nursing practice***

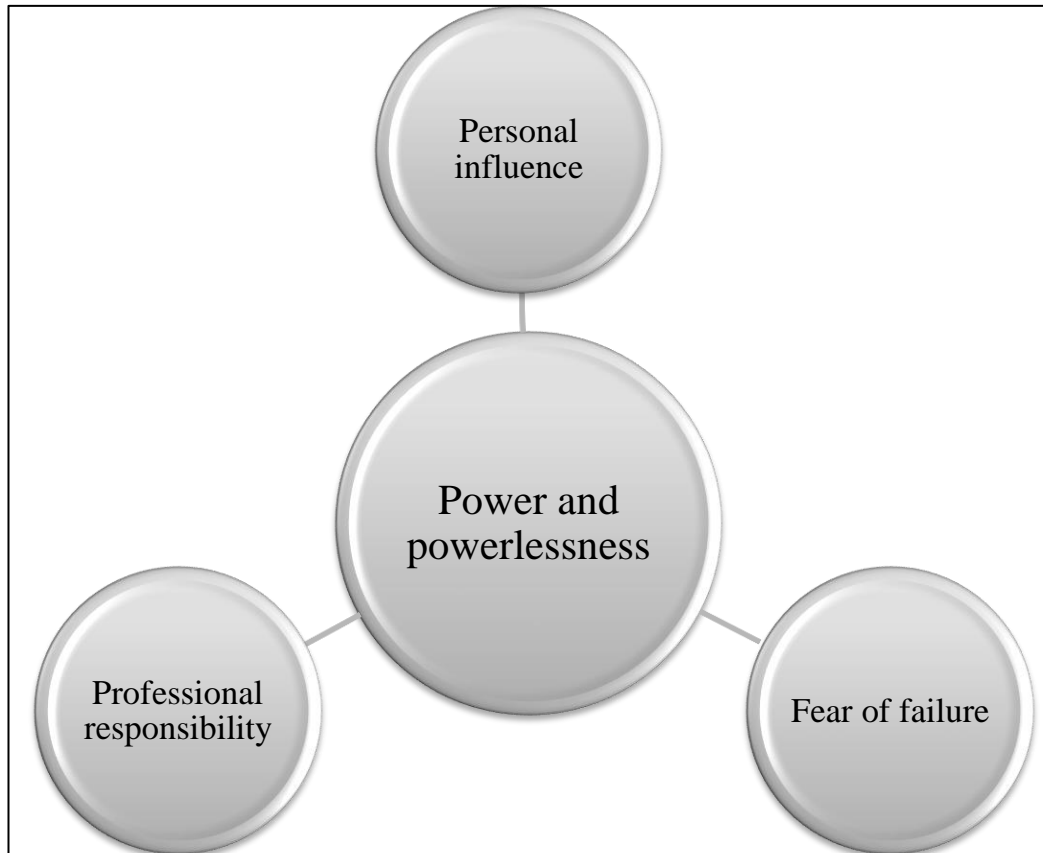
Participants, as student nurses, did not feel part of the team. They described being ignored and how this had an impact on their confidence and ability to make service improvements. A noteworthy finding was the perception of fitting in, changed when participants were registered nurse. The participants later felt part of a team and described having support from colleagues that contributed to their ability to make service improvements. These perceptions were important as participants recognised how this helped them to build confidence and determination in their ability to make service improvements. The participants valued on-going learning through experience, preceptorship and dialogue with colleagues.

Learners develop new knowledge through their interactions with their environment, social connections and through making sense of their experiences (Thomas et al., 2014). Through this transformation, the participants were developing resilience and feeling empowered.

#### **6.4 Theme Three: Power and powerlessness**

As students and later as registered nurses, the participants discussed an awareness of power in context of making changes through service improvements. The participants were aware of power as a dynamic in the clinical environment and that this influenced how they approached and undertook service improvements in practice. Power and powerlessness emerged as an important feature in how participants experienced service improvements in nursing. Nursing occurs in a social environment, where power impacts nurses in context of their working situation (Gray & Thomas, 2005; Bradbury-Jones et al., 2008). Power pervades social norms (Potter, 2003) and sustains power imbalanced relationships (Gray & Thomas, 2005). In this context, this theme had three related sub-themes namely: ‘personal influence’, ‘fear of failure’ and ‘professional responsibility’. Figure 21 illustrates the key theme and emerging sub-themes:

**Figure 21 Power and powerlessness**



#### ***6.4.1 Sub-theme one: Personal influence***

Participants, as both students and registered nurses described their personal influence and how they approached and made service improvements.

During interview one, participants as student nurses, described feeling powerless to make service improvements in nursing. These participants suggested their status as student nurses directly affected their ability to make service improvements:

*“There was nothing, nothing [service improvement] I could do as a lowly student nurse” (P2 Interview 1 Line 51)*

*“I am still in my little white student nurse uniform, not higher up. I have no power. I think a lot of people expect service improvement to come from higher up” (P9 Interview 1 Line 21)*

*“I think it makes you feel a bit of an underdog. When you are trying to implement something and they [work colleagues] are going against you and you are not in a position where you can sort of have any responsibility or power to do anything, you just have to take it” (P18 Interview 1 Line 99)*

Interview notes taken during these recordings, highlighted these participant’s non-verbal communication; they shook their heads from side to side as they articulated their perceptions and feelings. They expressed that having a lower status than their work colleagues meant that they had little personal influence to make service improvements. The participants used descriptions including ‘underdog’, ‘lowly student’ and ‘little white student uniform’ to highlight their perceptions of their student status, lack of power and suggested feelings of disempowerment. These findings correspond with Smith and Lister (2009) and Bradbury-Jones et al., (2011) who found that students felt powerless because of their low status and that they were not able to influence changes in practice. Bradbury-Jones et al., (2008) maintain that nursing is hierarchical. Some individuals hold control; prestige, power and status, whereas others have more subordinate positions (Bradbury-Jones et al., 2008). This is consistent with a poststructuralist view, which contends that power is associated with authoritative leadership and resides in a hierarchical structure where people are able to restrict another's freedom of action (Kuokkanen & Leino-Kilpi, 2000).

One participant discussed a conflict between their education, which taught them about the importance of service improvement and their lack of personal influence to change nursing practice:

*“It [service improvement] should not be about what they [work colleagues] say it should be about. It’s about what’s best for the patient and using guidelines and respecting patients” (P18 Interview 1 Line 59)*

They appeared frustrated by this situation going on to suggest that:

*“It goes against what we are taught” (P18 Interview 1 Line 61)*

Another participant suggested that they would be derided for even suggesting ideas for service improvements:

*“As a student you think they [work colleagues] are just going to laugh at me here even trying to suggest that [service improvement]”* (P13 Interview 1 Line 89)

These findings provide evidence that these participants perceived feeling not valued or respected by work colleagues and suggested they were disempowered in making service improvements. This corresponds with other studies that have found nursing students emphasise the importance of being respected and valued by colleagues and associate this with a sense of empowerment (Bradbury-Jones et al., 2007; Bradbury-Jones et al., 2011). Another participant described how their ward manager repeatedly ignored their service improvement suggestions and this experience left them feeling disempowered in making service improvements:

*“I left it [service improvement idea] on her desk [ward sister] and she just sort of ignored it. So I was just like[sic] nothing seemed to happen even though I was on their backs [sic]. Nothing seemed to be done”* (P13 Interview 1 Line 43)

Disempowerment is characterised by feeling excluded; de-valued, being treated insensitively and feeling unable to make a difference (Bradbury-Jones et al., 2011). The dissonance between the participant’s suggestions for service improvement and their powerlessness to make changes appeared to influence their confidence and ability to make improvements. Participant 13 went on to clarify how their feelings of powerlessness, repeated rejection and the ignoring of their service improvement ideas, seemed to erode any confidence they may have had:

*“I just thought well it’s all right. Until you get knocked back the first time, and when you get knocked back again and you think well they are not listening to me anyway. Why bother”* (P13 Interview 1 Line 45)

This finding is consistent with Bandura (1997a) who maintains that a belief of being powerless can create psychological barriers that are more incapacitating than external challenges

During interview two, participants as registered nurses described a change in their perception of power and their personal influence in making service improvements. It was evident that these participants' perception of power had changed from their student nurse experiences and perceptions:

*"It's completely different. I am aware of it in every single thing I do. I am aware of it in small things every day that you can do to improve the service. You can now see where the flaws are and you can say well I'm not happy with this. We have the power now to say, 'maybe we can change it?'" (P16 Interview 2 Line 54)*

*"Now when qualified you do have a say [in service improvement] and it's important that I do speak up and you do have the power to say how things are done" (P1 Interview 2 Line 62)*

These participants indicated that they had moved from being powerless as a student nurse to being empowered as a registered nurse. As registered nurses, the participant's status was higher than when they were students. This perception of power can be viewed through a poststructuralist lens. Foucault's (1995) construct of power, where disciplinary and knowledge power, emerges as a result of the participants increased status and ongoing experience of service improvement. Power is universal, it is not fixed; rather it stems from every force in society and with each interaction (Foucault 1995, Kuokkanen & Leino-Kilpi, 2000).

One participant made a significant statement when describing a change in their perception and influence in making changes through service improvements. This participant stated they would persevere with service improvement despite challenges and believed they now had the power necessary to make changes in practice. They intimated that they were



developing resilience in that they would persevere with improvements despite potential challenges:

*“I am not willing to put up with how things are, this has probably gone on for a long while and I am trying to change things for the better. I feel confident enough in myself to believe and I have a belief that if something needs to be changed for myself and the team and in particular patients, then nothing would stop me and I would do all that I could” (P15 Interview 2 Line 84)*

#### **6.4.2 Sub-theme two: Fear of failure**

As student nurses, several participants described a fear of failure making service improvements in practice:

*“I went into it thinking ‘well I can’t do it [service improvement]. It’s a little scary at first; you go out and look at the literature base behind the service improvement” (P7 Interview 1 Line 25)*

*“When I did my service improvement, I felt scared and I didn’t know if I had done it right” (P17 Interview 1 Line 39)*

*“I kept thinking I don’t want anything too big where I have to do all of that. In case it all goes wrong and I can’t do my [service improvement] project” (P1 Interview 1 Line 95)*

These participants who were describing being fearful, avoided making suggestions for change or attempting to make improvements, implying that they lacked self-efficacy in making service improvements. O’Mara et al., (2014) discovered that student nurses often fear making mistakes in clinical practice because of the challenges and uncertainty about what may happen. Too much challenge can over-whelm insecure students causing them to doubt their abilities and making them want to withdraw (Levett-Jones et al., 2009a). Bandura (1997a,b) contends that individuals who are ineffective in their performance are not ineffective because they lack skills and knowledge, rather because they lack a sense of self-efficacy (Lauder et al., 2008). Bandura (1997a, b) and Lauder et al., (2008) found that low levels of self-efficacy can produce avoidance behaviour. Daiski (2004) suggests a lack of support from work colleagues is a contributing factor in disempowering student nurses.

Other participants stated they were not afraid to make suggestions or attempts of service improvements. These participants described how, despite potential challenges or barriers they would still attempt to make services improvements:

*“If something needs improving that will improve the service that the patients are getting, then I would have no problem in giving it a bash to see if I can get something implemented to improve the service they are getting” (P12 Interview 1 Line 96)*

*“I would have no problem saying 'can you just back me up' [with service improvement]. If people just say no, then I'm thick skinned enough to just say 'fair enough really'. Your loss” (P2 Interview 1 Line 49)*

These participants both demonstrated characteristics of courage, commitment to make improvements and resilience in these statements. It is reasonable that this reflects the 6C's of nursing which include courage and commitment (Hardacre, 2014). Maturity may also be factor, P12 was 21 years and P2 was a mature student (32 years) at the time of interview. I asked P 2 to if they would 'give me a little more information?', they replied:

*“Having tried my own service improvement, I know that I need a lot more support. There's always someone in a care setting to help you, who will listen and back up your ideas” (P2 Interview 1 Line 100)*

This finding suggests that Participant 2 felt valued as a learner, listened to and supported by her work colleagues. Bradbury-Jones et al., (2011) found that when nursing students feel valued as learners and have a sense of belonging to the team, they feel empowered. Participant 2 highlighted how they had experienced service improvement and were not afraid to ask for help from colleagues for their future service improvement ideas. Stephens (2013) found students who experience success in practice; develop enhanced coping and adaptive abilities.

During interview two, when the participants were registered nurses, it appears that perceptions and fear of failure in service improvement had changed. Several participants reflected on concerns that they had during their initial post registration period, describing

being worried about making suggestions for service improvements and how work colleagues would perceive them:

*“At first I wasn't too good at that [service improvements]. It was a new role and I didn't want to feel or make it come across that I couldn't cope” (P12 Interview 2 Line 87)*

*“I think when I first started I think I was wary of saying things in case I sounded stupid, because of being newly qualified. I am not confident in something that I say, in my head, I know it, but I am not confident to say it out loud in case it sounds stupid, or it is wrong.” (P3 Interview 2 Line 69)*

When I asked if they could tell me more about these experiences and feelings, the participants suggested that as they moved along the trajectory of being a registered nurse, they had gained confidence and self-belief in their ability to make changes and were no longer afraid to identify areas that would benefit from service improvement:

*“As I am getting further on [as a registered nurse] I am more confident and more settled in my role. Now I am not frightened” (P12 Interview 2 Line 96)*

*“Now I think if I say it and it's wrong, well then, what's the worst thing that's going to happen? So I think I have developed in the sense of my confidence growing and I don't feel the need to worry that I might say something wrong. I am happy to say it and be told what was wrong than to worry about it” (P3 Interview 2 Line 77)*

These participants indicated that they would try to change practice through service improvements regardless of their previous fears of failure, suggesting a growing confidence in their ability. Self-confidence underpins a nurses' competence to carry out their role effectively and is linked to the concepts of resilience, empowerment and self-efficacy (Crooks et al., 2005). These findings suggest that participants were developing resilience; they were no longer fearful in suggesting or making service improvements and were determined to make improvements despite challenges or fear of how colleagues may perceive them. P3 went on to offer further explanation:

*“I don't feel the need to worry that I might say something wrong. I am happy to say it and be told what was wrong, rather than to worry about it” (P3 Interview 2 Line 78)*

A person's sense of self-determination is demonstrated as resilience (Hart et al., 2014). McAllister & Lowe (2011) suggested that resilience is measured by how well individuals bounce back and cope successfully despite sometimes unfavourable circumstances.

#### **6.4.3 Sub-theme three: Professional responsibility**

As student nurses, the participants viewed their professional responsibility for service improvement in different ways. Several participants described not being responsible for service improvements; seeing their role as supporting or contributing:

*“As a student I think our role at the minute is just to put an idea across or maybe a plan across to maybe the mentor or the ward sister. We are not responsible but if we have an idea of what could be improved and maybe have an input on what we can do and try and facilitate it with the backing of staff” (P12 Interview 1 Line 94)*

One participant described a traditional pedagogical approach to the teaching, which they experienced in clinical practice. They felt they were not able to contribute to, or have responsibility to make suggestions for service improvements and that this approach to learning did not facilitate their involvement:

*“Our role is to be involved [in service improvement] but it's like the traditional role of the teacher talks and the students listen and you are not given the chance of thinking for you own self. We are probably not involved in the entire process, just involved in the implementation of a service improvement because we don't have any responsibility in the same as a registrant,” (P19 Interview 1 Line 76)*

Bradbury-Jones et al., (2011) found a lack of responsibility can be a significant issue for student nurses and had a negative impact on their learning.

Nevertheless, other participants felt that they were able to contribute to service improvements:

*“I think that for the wards that were like my ward where there was no change going on, we can bring the change in” (P7 Interview 1 Line 100)*

*“I can see that you can implement things yourself, to a certain level you can anyway” (P6 Interview 1 Line 89)*

*“As student nurses we should to continually look at their own practice to improve future care and innovate different practices” (P8 Interview 1 Line 41)*

This finding reflects other research where student nurses reported valuing service improvement in their pre-registration programmes (Smith and Lister 2011; Smith et al., 20014; Baillie et al., 2014) and see it as important for professional development and patient safety (NHS Institute for Innovation and Improvement, 2008a). Crooks et al., (2005) found student nurses felt empowered to initiate change through positive educational experiences underpinned in clinical practice. Empowerment is akin to having a voice for nursing students (Bradbury-Jones et al., 2007).

Several participants articulated the differences between student and registered nurses in making service improvements and that their responsibility as registered nurses would be different:

*“I know they say you should always make changes even as a student but it thinks it is difficult. I think that once I'm a staff nurse and I am established on a ward and I have found my place if I think something could be done better or in a certain way I would do it” (P20 Interview 1 Line 41)*

*“I think it is important to get involved [in service improvement]. As a student I think you definitely can be involved when the opportunity arises. It would be a good opportunity to get involved as a student. As when you qualified, it's more important to be able to do things like that [service improvement] and recognise the need for change. It's your responsibility” (P11 Interview 1 Line 59)*

When registered nurses, during interview two, participants reflected on their experiences as student nurses and discussed the difference in their responsibility and accountability in

making service improvements. As a registered nurse, Participant 11 reflected on their perceptions as a student by stating:

*“Once you are qualified it comes down to you being a lot more accountable and you understand your responsibility a little bit more” (P11 Interview 2 Line 84)*

Other participants shared similar reflections from student to registered nurse and described the differences in their responsibility as a registrant:

*“I think I was quite naïve as a student to the whole service improvement thing, I did not pay it as much attention as I should have done. Being qualified it does open your eyes a lot more to it because you are responsible and accountable for your patients. I think you have more power now for service improvement and I think they look at you differently now” (P5 Interview 2 Line 85)*

*“You are more pro-active as a qualified nurse, you are more responsible to look at things to be improved and make sure your service is better for patients. You are more accountable as a staff nurse and you see things easier, ‘cos [sic] you are working there. As a student you are supernumerary and it’s more difficult to put your opinions across and say this might need to be changed as a student you might not be as confident. But as a staff nurse you have got the power and can be an advocate for your patients and improve the service for them” (P12 Interview 2 Line 109)*

*“When you are qualified your opinion matters, not that it doesn’t matter as a student. I think if you did have a good idea as a student, people would listen, but I think it’s harder to get people to buy into it. Whereas if you say something as a qualified member of staff, once you have that uniform on it is different” (P8 Interview 2 Line 41)*

The participants described having responsibility, accountability and the personal influence to be able to make service improvements, suggesting they had the determination and ability to make changes happen. These findings reflect Feng and Tsai’s (2012) who discovered that newly registered nurses were less likely than student nurses to compromise their care standards in order to maintain the status quo. Newly registered nurses are willing to challenge and persevere with service improvement ideas as they can see the benefits for patients (Feng and Tsai, 2012).

Participants were clearly undergoing a professional transformation from student to registered nurse as they became responsible and accountable for service improvements. They reflected on their experiences and how they became empowered and resilient to make service improvements despite potential resistance or challenges. This finding supports Kuokkanen & Leino-Kilpi (2000) who found that registered nurses, who feel empowered, display characteristics including personal integrity, courage and tenacity.

#### ***6.4.4 Summary of Theme Three: Power and powerlessness***

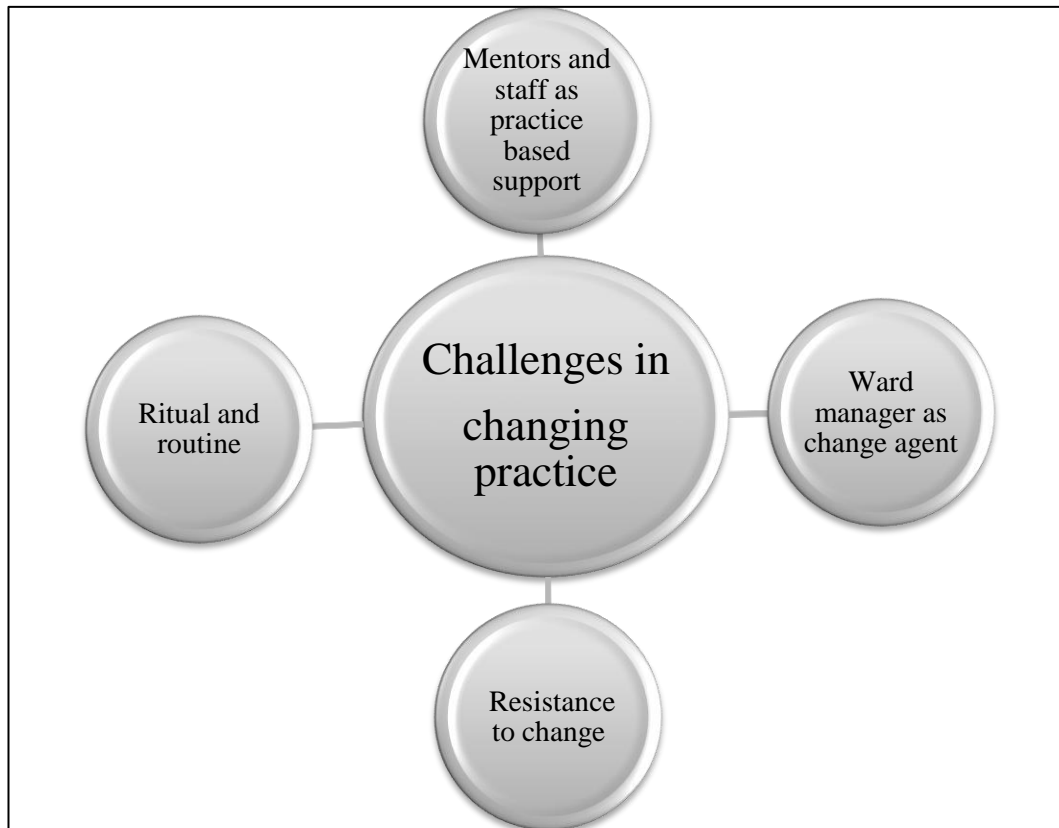
Theme Three has illustrated that the participants were undergoing a process of professional transformation from student to registered nurse. Professional development begins during undergraduate education and continues through education and practice for registered nurses working in clinical practice (Davis et al., 2014; Coventry et al., 2015). The participants recognised their role had changed and they now had power, personal influence and an individual responsibility to make improvements. Through this process, they became empowered in making service improvements. The participants were demonstrating a growing sense of empowerment and resilience, linked to their change of status, increased confidence and level of responsibility.

### **6.5 Theme Four: Challenges in changing practice**

Theme Four was ‘Challenges in changing practice’. There were several sub-themes associated with challenges to change. These included ‘mentors and staff as practice based support’; ‘ward manager as change agent’, ‘resistance to change’ and ‘ritual and routine.

Figure 22 illustrates the key theme and related sub-themes:

**Figure 22 Challenges in changing practice**



#### ***6.5.1 Sub-theme one: Mentors and staff as practice based support***

Student and newly registered nurses are supported in their practice settings by mentors and other staff. These are important in order to facilitate learning and skill acquisition. Student nurses are supported in their clinical practice by mentors and co-mentors. Mentors hold different professional positions on the ward including staff nurse (Band 5), sister (Band 6) and ward manager (Band 7). Participants both when students and registered nurses, described working alongside mentors and staff in order to identify areas where service improvement could enhance care and the patient experience.

During interview one as student nurses, several participants described negative experiences of service improvement and attributed this to the level of support and engagement they



received. These participants expressed feeling unsupported by mentors and work colleagues and this affected their ability to make service improvements, suggesting feeling disempowered:

*“I explained it [service improvement idea] with my mentor and she said ‘that’s good’ and then said ‘you have got to speak to the ward sister or manager’. I then had to speak to them and it was just kind of ‘well if you come back on this day.’ And then nothing got done about it that day. And nothing got done about it at all”* (P13 Interview 1 Line 23)

*“In trying to get my leaflet implemented, the ward sister and mentor, they loved the idea which I had, but they weren’t very forthcoming in actually trying to help me to implement it properly in practice. They just thought it was a good idea and they left it all just down to me”* (P12 Interview 1 Line 31)

Using probing questions, I enquired, ‘can you tell me a little more about that?’, P12 replied:

*“I expressed to them [mentor] that I didn’t have the confidence to approach the matron and people like that to get it implemented and they just didn’t seem that interested”* (P12 Interview 1 Line 33)

Although these participants gained verbal support for their service improvement ideas, there was a lack of support from mentors and colleagues in helping them to make changes. The findings in the current study correspond with Baillie et al., (2014) who found some student nurses did receive positive affirmation from staff with their service improvement ideas but were not able to put their service improvement learning into practice through a lack of support. A plausible explanation for the finding in this study may be due to staff lacking confidence in their own knowledge and ability to make service improvements. Wilcock et al., (2009) found that despite service improvement being taught in nurse education, many nurses lack the knowledge and skills needed to undertake service improvement in practice.

Other participants as student nurses expressed experiences that were more positive, where they had support for service improvement from their mentors. These participants discussed a collaborative, student-centred approach in how their mentors facilitated their learning.

Several participants identified key attributes to mentoring. These findings suggest that the support from and interactions with mentors were empowering for them:

*“It depends who you work with. You can have some mentors, charge nurses and sisters who are quite good at facilitating change and asking for ideas and they have some respect for the student, you are not just another body”* (P19 Interview 1 Line 39)

*“I think she (mentor) was just brilliant ‘cos [sic] she respected student nurses and you do not often get that. My co-mentor, he was on the ball, he was great. I learnt so much from him on policies and clinical governance, everything. He was a role model for me. So again it depends who you get when you get out there.”* (P14 Interview 1 Line 16)

*“The conversation came ‘that it works on our ward’ so they thought well shall we give it a try as well and plus the staff were very good at listening to each other. They weren’t kind of ‘oh well’. They would listen to your ideas and ‘yes what can we do to improve it?’”* (P1 Interview 1 Line 65)

*“I spoke to my mentor about it and my mentor was really good about it, she was helping me and helping to develop it [service improvement]”* (P11 Interview 1 Line 33)

These comments highlight positive attributes of effective mentors who helped facilitate learning and service improvement experiences for the participants as student nurses. Participants described positive mentor attributes including having respect for students, facilitating change, sharing knowledge, being motivated and being a positive role model. These findings are consistent with other research which identified similar characteristics of effective mentors including teaching and evaluation, being positive, devoting time to students, being an effective role model, being supportive and facilitating learning opportunities (Elcigil & Sari, 2008; Gignac-Caille & Oermann, 2010; Huybrecht et al., 2011; Luanaigh 2015).

Participants also considered their mentors as role models through their facilitation of learning, motivation and involvement in service improvement. Mentors who are effective role models have a positive influence on student learning and students feel involved with practice when given opportunities to work with positive role models (Bahn, 2001; Levett-Jones et al., 2009b). My participants described how they were empowered and motivated

to be successful in making service improvement through the supportive interactions and experiences of positive mentoring. Bandura (2002) found learning is acquired through modelling effective role models who are seen to empower individuals to develop personal values that motivate them to improve.

Participants described the ways in which mentors helped them to present their ideas for service improvement and supported them in taking their suggestions forward:

*“They [mentors and staff] were very supportive and helpful. Giving me tips about how to be more assertive when presenting the case to the ward manager. They were giving me examples of what I could say, helping me with the research and helping me with the correct people to talk to” (P17 Interview 1 Line 23)*

*“I had a staff nurse mentor who had past experience of service improvement and I found I learnt a lot more off her than anything. I could see what she did as she did it. We just simply went through what could we change, and then how could we change it, getting the evidence we needed and discussed it again as a team and then started to implement the change.” (P9 Interview 1 Line 19)*

These descriptions provide evidence that those participants who felt supported by mentors and colleagues had more positive experiences in making service improvements.

This finding is consistent with other studies where student experiences of service improvement were heavily influenced by the mentor, who was seen as essential to student learning and for their success in practice (Gray & Smith, 1999; Christiansen & Griffith-Evans, 2010; Williams, 2012; Andrews, 2013; Baillie et al., 2014). Social constructivists highlight the need for mentors to facilitate active learning and positive social interactions with their nursing students (Kala et al., 2010). Active learning is a vital determinant of successful learning and the social context enhances effective learning (Kala et al., 2010). My findings also reflect the importance of social and adult learning theories, where social interactions promote student learning experiences (Green et al., 2014) and students are encouraged to learn within their ZPD (Vygotsky, 1978).

During interview two as registered nurses, several participants described work colleagues who supported their suggestions for service improvements. Participants described taking their ideas to colleagues and how they could share ideas, gauge support and gain assistance for their service improvement suggestions:

*“She [a colleague] was really receptive to it. She understood where I was coming from. She was a great help to me” (P2 Interview 2 Line 33)*

*“I would go and see the other nurses and see what they thought and if there was enough ‘oomph’ [sic] behind it. We have a lot of research nurses and things involved on the ward. They are a great support” (P4 Interview 2 Line 37)*

These comments suggest participants appreciated a collaborative approach to service improvement where they received support to change practice through their social interactions within their clinical team. Kolb (1984) described a learning cycle where lessons are learnt through being adaptable and open to changes. These participants were reflecting on their experiences and they were articulating why and how things occurred (Kolb, 1984). The participants valued talking to other members of their team who were also enthusiastic about making service improvements. This corresponds with Bandura (1985) who found the importance of the social environment and social interactions through which learning occurs.

One participant described how they worked as a ‘connected group’, where they came together to discuss service improvements:

*“The clinical educator is the one; she's the one up to date with all the policies and everything. She's the one who is always passing stuff onto us, she is just amazing. You need to be able to discuss it [service improvement] as a connected group. That's why we have the meetings where we will discuss it” (P10 Interview 2 Line 31)*

These findings are consistent with other studies that found motivated staff encourage others to be engaged in service improvements (Tingle, 2011; Wilkinson, Powell, & Davies, 2011).

### **6.5.2 Sub-theme two: Ward manager as change agent**

The ward manager or sister was perceived as being important when developing service improvement suggestions for participants when both student and registered nurses.

As student nurses, participants described how the ward manager was accessible, supportive and facilitated their service improvement ideas:

*“There were always open lines of communication with the ward manager and the clinical lead which I found more than in any other placement. So I think that hit the nail on the head. They were great”* (P12 Interview 1 Line 15)

*“I had an idea with my mentor on the ward. The ward manager, when we went to her, she was on board straight away”* (P15 Interview 1 Line 32)

*“I think the ward manager was really good, she was hands on and she was driving all the service improvement and engaging the patients with the staff and the staff knew all the patients, it was really patient centred”* (P17 Interview 1 Line 19)

Others suggested that the ward manager’s status and leadership was an important factor in making service improvements:

*“You can only move forward if you have a really good manager who, with their communication skills, gets everybody on board. If you don’t have the higher management on board to facilitate your idea, it’s not going to get any further forward”* (14 Interview 1 Line 27)

*“I think hierarchy comes into leading it [service improvement]”* (18 Interview 1 Line 21)

*“The sister can implement it [service improvement] that way ‘cos [sic] it does take a higher person to say to the other higher person ‘oh this is a good idea’”* (13 Interview 1 Line 22)

*“The ward manager, they are at the top so they are showing the staff and leading by example. If the staff see the manager doing it then they will think I should be helping or be involved in that”* (17 Interview 1 Line 27)

These findings are consistent with other research which found that ward managers have strategic responsibility for their ward through being an effective leader and promoting positive working environments (Koivula et al., 1998; Locock, 2003; McGowan, 2006; Christiansen & Griffith-Evans, 2010; Shafer & Aziz, 2013; Coventry et al., 2015). Leadership and management are taught components in the third year of the pre-registration

nursing programme. It is therefore unsurprising that my participants recognised that the ward manager's authority, responsibility and power was required in order to be successful in service improvement.

One participant described feeling anxious about making suggestions for improvements until they had shared their ideas with the ward manager. When they received a positive response, their perceptions changed:

*"At first it was a bit daunting. I was a bit worried and not confident but it I think once I got the backing of the ward manager she was supportive. I got into it and stuff. They were just very supportive and helpful and giving me tips about how to be more assertive when presenting the case to the ward manager. And they were just giving me examples of what I could say. Helping me with the research and helping me with the correct people to talk to"* (P17 Interview 1 Line 30)

Another participant reflected on how the ward sister was particularly interested in them as a student and appeared to value the contribution they brought to the clinical area:

*"They [ward sister] wanted to know what a student's thoughts where, when a student came in from the outside and saw how that ward was run she asked me in particular 'You are a different set of eyes coming in what, is there anything that needs changing, with what you have seen?'. It was good that at the end of my placement. I said, "Yes there is" and I don't think I would have gone forward with it [service improvement] if she hadn't have asked. She said 'You know you are the ones from university, you are the ones for the future, you are getting taught at university everything is contemporary and I want to know what they are saying'"* (P14 Interview 1 Line 15)

The role of the ward manager in making changes in practice through service improvement continued to be a feature when the participants were registered nurses. During interview two, participants described how their ward manager supported and listened to their suggestions:

*"They will help and they are open to new suggestions"* (P2 Interview 2 Line 35)

*"Your managers, definitely our ward manager supports change and values your ideas and always listens to what you have to say"* (P6 Interview 2 Line 21)

*“They [ward manager] are confident, they are a strong leader. They are supportive open to all members of staff opinions; not only listening to senior member’s staff, but listening to everybody” (P16 interview 2 Line 29)*

*“I would go and see the sister and ward manager and see what they thought of it and see if there were any ways to bring it in” (P4 Interview 2 Line 27)*

Participants discussed that the ward managers power and authority as being pivotal in making service improvements. These participants suggested they would seek this delegated power to empower them to make improvements:

*“The ward sister in terms of leadership is really important in service improvement. You need a strong leader to make it [service improvement] happen. They are the ones who let you do it [service improvement]” (P5 Interview 2 Line 33)*

*“It’s the sister in charge who leads it [service improvement] and makes it happen. There are various different groups you can go to and get involved in it but she gives you the power to do it” (P16 Interview 2 Line 33)*

*“You have to get your ward managers approval for whatever you are doing [service improvement]. But most of them, because the way things can be with targets and stuff like that, are mostly quite receptive to things, to your ideas. They will help you do it and they are open to new suggestions” (P2 Interview 2 Line 35)*

*“Ward wise it [service improvement], it would be from the ward manager. They are the ones who drive it and help you do it” (P1 Interview 2 Line 30)*

These findings provide evidence that the participants were becoming empowered to make improvements through their ward managers leadership, authority, power and support. Empowered nurses have courage, tenacity and self-esteem (Kuokkanen & Leino-Kilpi, 2000). This is consistent with Madden (2007) who found that registered nurses experience high levels of empowerment when their ward managers nurture perceptions of autonomy, confidence and meaningfulness. This corresponds with other studies which found strong leadership and effective managers are fundamental to empowering staff by providing access to information, resources and support and through removing barriers through increased commitment (Madden, 2007; Faulkner and Laschinger, 2008).

Participants described a feeling of being safe when discussing suggestions for service improvement with their ward manager:

*“I think it comes from your manager, charge nurses, as well as us. They have to make it a safe environment where if there are any problems you can come and talk to them. That way you can see if there a need to change and they can help you do it” (P10 Interview 2 Line 33)*

*“It’s about not being frightened to say that you are struggling with something and be confident enough to say that to your manager” (P12 Interview 2 Line 47)*

When clarifying this by asking ‘It’s about being safe. You mentioned feeling safe?’ P12 replied:

*“I would not have a problem. I would go to the manger with an idea saying this could be improved and if she was happy she would say go ahead and try and do something about it” (P12 Interview 2 Line 63)*

These comments suggest the ward manager was important in developing a culture where service improvements are encouraged and supported. Christiansen & Griffith-Evans (2010) found ward managers contribute to an organisational philosophy that incorporates change as a core value and results in a culture that embraces service improvement.

Alongside the ward manager, participants also identified other healthcare professionals who had a role in facilitating service improvements. Participants also discussed enlisting the support of healthcare colleagues in order to support ideas for service improvement:

*“In terms of implementing things [service improvement], it would be through senior members of staff” (P16 Interview 2 Line 35)*

*“We have a lead consultant and so they [ward manager] work together with matron quite a lot and they help follow things through. Even if it’s just small, I would go to them for the backup. This is what I want to do and why and they have the enforcement to make it happen, and they can drive it” (P19 Interview 2 Line 13)*

*“We have a research link nurse who drives it [service improvement] and the ward managers. They let you do it [service improvement]” (P12 Interview 2 Line 35)*

*“We have a lot of research nurses and things involved to improve things on the ward. We also have a clinical educator and ward manager who we go through with ideas. They listen and tend to cascade the information down” (P14 Interview 2 Line 13)*



These participants described actively seeking colleague's views; ideas, knowledge, motivation and support to take forward their suggestions for change. These findings are consistent with Carlin & Duffy (2013) and White et al., (2014) who found that newly registered nurses identified positive characteristics of colleagues supporting them in practice. These characteristics included promoting teamwork; fostering a sense of belonging, offering support and being positive role models within organisational cultures, which have a commitment to service improvement and enable improvements to take place (Christiansen & Griffith-Evans, 2010).

### ***6.5.3 Sub-theme three: Resistance to change***

Resistance to change was a feature participants experienced in relation to trying to change practice through service improvements as both student and registered nurses.

As student nurses, participants identified service improvement as a difficult and challenging process. One participant succinctly noted:

*"I think that it's difficult to bring about any change as a student"* (P15 Interview 1 Line 19)

Other participants suggested resistance to service improvement was due to staff being uninterested or not wanting to change their existing practice, suggesting being disempowered to make improvements:

*"People don't always receive it [service improvement] positively because people don't always like it. People know what's the norm, what's happening and they don't like change"* (P12 Interview 1 Line 24)

*"I think a lack of interest by the nurses; some professionals are just not interested in service improvement. I think a lot of people just get stuck in their own ward and ward routine"* (P17 Interview 1 Line 15)

These findings correspond with Johnson et al., (2010) who found that resistance to service improvement was a common phenomenon that many student nurses encounter.

Some participants described how they felt disparaged for suggesting ideas for a service improvement and attributed resistance to service improvement to their student status:

*“They [staff nurses] made me feel like I had a really rubbish idea and that it wasn't really good. It also made me feel like the staff nurses, sort of felt that I was a bit silly ‘cos [sic] I am a student nurse. I had picked up on something that wasn't working and they were a bit defensive. I think every little helps, but I do think that as a student, staff nurses get in the way. They put barriers up to prevent things happening and I think a lot of it is because they don't like change”* (P15 Interview 1 Line 19)

*“I think a lot of people expect service improvement to come from higher up. I think if the managers say it they [staff nurses] might still complain about it but they know they have got to do it. Whereas coming from a student I think some people might just think ‘I'm not going to do that, it's just a student’”* (P9 Interview 1 Line 10)

*“In practice it is hard for you to implement service improvement. People don't want to change. It's being a student; how do you implement these changes being a student?”* (P18 Interview 1 Line 15)

These findings correspond with Bradbury-Jones et al., (2008) who found that within nursing, some staff hold control, power and status, whilst others, including student nurses, hold more subordinate positions. Other studies have also reported that students were unable to influence changes in practice because of their low status (Smith and Lister, 2009; Johnson et al., 2010; Bradbury-Jones et al., 2011).

There were several other factors, which participants identified as reasons for resistance to change practice through service improvement. Financial implications or impacts on existing resources were cited as reasons there was resistance to change:

*“It was an issue of funding. Therefore, that is needed for you to even think to say ‘I have an idea for a service improvement’. You need to have some background first”* (P1 Interview 1 Line 75)

*“Another is financial implications and the cost of changing anything”* (P20 Interview 1 Line 17)

*“There was a bit of uncertainty about it [service improvement], it sounds silly, but the actual resources were an issue”* (P11 Interview 1 Line 19)

*"The cost was thrown at me quite a bit 'cos [sic] it was how you are supposed to fund this kind of thing?" (P16 Interview 1 Line 23)*

Participants also discussed time constraints as a factor in resistance to change practice through service improvements:

*"A lot of the staff were not happy about change; they thought it was all a waste of their time" (P5 Interview 1 Line 26)*

*"I think a lack of time, a lack of interest by the nurses; I think some professionals are just not interested in service improvement" (P17 Interview 1 Line 14)*

*"One thing I would like to have changed but there was no time to do it. Time was a big factor" (P18 Interview 1 Line 18)*

*"Because they might not have the time to do the extra improvement or they might claim not to have enough time. Time, and resources perhaps and maybe they haven't been shown the benefit of doing things differently" (P19 Interview 1 Line 22)*

These findings are consistent with other research by Johnson et al., (2010) and Baillie et al., (2014) who found ward staff reported a lack of time, lack of resources, increased workload and low staffing levels were barriers to service improvements.

Several participants described mentors being resistant to their proposals for service improvement with some staff actively putting up barriers to their suggestions for change. As student nurses, these participants described how, negative experiences and resistance to service improvements, made them feel frustrated and disempowered:

*"You get to the point where you think they are not going to change and you think what the point is? I know that's not the right kind of attitude. I know we have to keep banging on the door" (P20 Interview 1 Line 23)*

*"What a waste of time.! I thought maybe I shouldn't have put so much effort into it [service improvement] if they [ward staff] are not going to be bothered about it" (P13 Interview 1 Line 9)*

*"They [the staff] make you feel like what is the point of bothering when you are saying things and they keep saying 'No'" (P20 Interview 1 Line 8)*

*"It should not be about what they say. It should be about what's best for the patient and within guidelines and respecting patients. That goes against what we are taught" (P18 Interview 1 Line 18)*

During interview two as registered nurses, participants continued to identify resistance to change as a phenomenon, which they experienced in relation to service improvement:

*“A lot of the time there is resistance” (P9 Interview 2 Line 37)*

*“People are often reluctant to change” (P6 Interview 2 Line 26)*

*“This ward manager said ‘a lot of nursing staff don't like change, they learn a way and they do something just because it is comfortable’, but she said it doesn't mean there shouldn't be change. There is always change, this is the NHS” (P14 Interview 1 Line 21)*

*“People don't want to change, people get stuck in their own ways, loads of different types of people” (P15 Interview 2 Line 24)*

*“The same people can block it [service improvement] and are resistant to change. There are one or two who are stuck in their ways and are resistant to change” (P2 Interview 2 Line 15)*

Despite these negative experiences some participants reflected on how some work colleagues were more receptive to making service improvements:

*“Not the whole team are as enthusiastic as they should be or into it as they should be, but there are a lot who are driven to improve the service” (P12 Interview 2 Line 33)*

*“Not all, but some [work colleagues] have been fine, really receptive to improvements. That makes the job easier, when they [work colleagues] are more of help than a hindrance” (P11 Interview 2 Line 36)*

These comments suggest that participants valued those colleagues who were supportive and receptive to making service improvements. O'Mara et al., (2014) found positive working relationships with colleagues could act as a buffer to unsupportive practice, negative cultures and adverse relationships. The impact of positive relationships, personal growth and professional reflection are strategies that enhance resilience in nurses (Jackson et al., 2007).

An interesting finding that emerged in Phase Two was that the participants recognised similar resistance and barriers to change which they identified when they were student nurses. Several participants as registered nurses described feeling that resistance to change

practice through service improvement was a result of a perception it would increase staff workload, suggesting this made it challenging them to make improvements:

*“The nurse who was resistant to change did quite well in voicing her opinion because there was too much work to do. We still have to try though and improve things”* (P14 Interview 2 Line 34)

*“I think its people [who are resistant] who want an easy ride and don’t want more work to do, but that makes it hard for us”* (P15 Interview 2 Line 37)

These findings are consistent with Carlin (2013) who identified concerns of increasing staff workload and competing work priorities were considered to be barriers to service improvement. Maben et al., (2006) found newly registered nurses were expected not to demand too much of, or add to existing staff workload. Plausible explanations for these findings in the current study may be that service improvement is often considered additional, rather than integral to nursing practice (Tingle, 2011). When service improvements are taking place, some work is allocated to other staff, making those staff feel they are working more; are less valued or engaged in the process (White et al., 2014).

Some participants discussed financial constraints and time factors as reasons for resistance to service improvement:

*“It comes down to money. Something may really benefit the patient, but it’s not always possible with the staff or the time. Money is a big factor in trying to improve things”* (P15 Interview 2 Line 27)

*“You don’t have as much time to do it [service improvement]”* (P6 Interview 2 Line 30)

The participants who identified cost and time constraints as barriers to service improvement were working in General Outpatients, Coronary Care Unit (CCU) and General Theatre. A credible explanation for the findings in this study may be to context specific pressures or challenges in clinical areas. Influences such as low staffing levels, complexity of patient care, waiting time targets or other factors may have influenced these participant’s perceptions of service improvement. Nursing in critical care environments, including CCU

and Theatre are considered high pressure and complex environments (Lan, Subramanian, Rahmat, & Kar, 2014). It is recognised staff working in high-pressure areas may not be as engaged in service improvement (Adriaenssens, De Gucht, Van Der Doef, & Maes, 2011). Barriers to service improvement in these areas include culture, high patient turnover, and complexity of services and lack of organisational capacity (White et al., 2014; Aiken, Rafferty, & Sermeus, 2014). Morrow et al., (2012) found that healthcare staff were often sceptical of service improvement, as they regarded the focus being on productivity and targets rather than the quality of services and patient experiences.

As registered nurses, some participants described their ward manager as lacking management and leadership skills and this resulted in resistance to change, which was not challenged or addressed:

*“Some levels of management pick up on service improvement but they don't enforce it ‘cos [sic] they are a bit intimidated by members of staff. So that's a block by the management whether that's intentional or not. But they don't tend to enforce [service improvement] much ‘cos [sic] they are intimidated and maybe they think they shouldn't be doing it?” (P19 Interview 2 Line 17)*

*“If you don't have a strong leader, they [staff] are just left to get on with it and be negative and say we have always done it this way. She [ward sister] is a lovely person but she is not really the best manager, she is very laissez faire, she just lets it run and people do things. If the evidence is good and shows we should be doing this change, for some reason people put blocks up and the management don't enforce it and say we need to do this. If you don't have a strong leader, they [staff] are just left to get on with it and be negative and say we have always done it this way” (P14 Interview 2 Line 18)*

It was evident through these comments that the role of the ward manager and strong leadership skills were perceived as being important in making service improvements, particularly when there was resistance to change. This reflects Melnyk et al., (2012) who found that nurses were often prevented from implementing service improvements due to resistance from managers and organisational cultures that avoid change.

Several participants described perceptions of negative personalities within their teams and that this can cause challenges when trying to make service improvements:

*“They [staff] don't like the job so they are always bitching about the job; it's an effort for them to be there. So they are not going to put themselves out to do something new [service improvement]” (P14 Interview 2 Line 33)*

*“You work better with some people than others, and sometimes if you have someone who is always negative, then it is draining but I just say 'get on with it' [service improvement]. If someone is constantly whinging it's a bit, 'just get on with it' it's quite hard to get other people to change” (P8 Interview 2 Line 101)*

On asking for further clarification, Participant 8 suggested:

*“I think if you are negative about something [service improvement] then you are not going to be in the right attitude to do something about it. But if you are happy to make the changes then it's a bit easier to implement into the role” (P8 Interview 2 Line 105)*

Checking my interview notes, they shrugged their shoulders when talking about negative attitudes to service improvements, but nodded their head when suggesting a more positive attitude made it easier to make changes.

In response to dealing with resistance to change some participants identified personal attributes and characteristics that they had developed, which allowed them to manoeuvre through resistance to change and be effective in making service improvements:

*“I think I deal with change well, I am one of those weird people who don't mind change and go along with it and try it. If there is anything else, I can add to it [service improvement] I always speak up and say what I think could be even better” (P8 Interview 2 Line 26)*

*“I think good communication skills; I think to be diplomatic, I think you need to be able to be open-minded and see other people's points of view. You need to do a lot of research into it and look into the reasons why people want to do service improvement and what's the underlying reasons as to why people want to change things, you have to look at the whole aspect” (P15 Interview 2 Line 3)*

*“I have always been approachable and somebody who would want to put things forward and be respectful of others opinions and work well in a team” (P16 Interview 2 Line 31)*

These comments are consistent with Baillie et al., (2014) who found that newly qualified nurses who had positive experiences of service improvement were able to encourage colleagues' involvement, develop positive relationships and protect against unsupportive practice, negative cultures and relationships (O'Mara, 2013). Development of skills and

behaviours is not a surprising finding as nurses are lifelong learners and develop a range of skills as they professionally transform from student to registered nurse (Benner, 1984).

#### **6.5.4 Sub-theme four: Ritual and routine**

During interview one as student nurses, several participants described being aware of established ward routine and rituals in their practice environment:

*“Just because you go on a ward, just because it’s there, it may be done historically just because it’s there. A lot of nursing staff don’t like change; they learn the way and they do something just because it is routine and comfortable”* (P14 Interview 1 Line 19)

*“The way some of them are quite set in their ways of the way they do things and they will go and do their assessment and they don’t want to change. They do the same thing day in day out”* (P15 Interview 1 Line 24)

These findings are consistent with Walsh & Ford, (1989) who discovered that nurses often complete tasks in a ritualistic manner which is unthinking; repetitive and lacking any empirical basis (Philpin, 2002).

Several participants commented that staff who had worked on a clinical area for a long period were less likely to engage in service improvements:

*“You see things that staff that have been there a long time don’t actually see. They are used to it. The way they are doing it isn’t always the right way”* (P13 Interview 1 Line 43)

*“Staff nurses, who have been working there a lot longer than me thought that they knew a lot more. So there was a bit of like [sic] tension there because I had identified something that could be possibly changed. I think they took it a bit personally as well as if they were not doing their job properly”* (P15 Interview 1 Line13)

*“I think it’s a big thing for students to have to tell older staff who have worked there for so long that actually, do you not think you should try a different way? I think sometimes that’s frowned upon a bit. Not that students shouldn’t, but maybe they are not expected to”* (P1 Interview 1 Line 35)



This corresponds with Baillie et al., (2014) who found that student nurses are able to identify barriers to service improvement, which include an unwillingness or ability by staff to change practice.

Other participants discussed ward routines and felt conformity was a barrier to service improvement and changing practice:

*“Everything was done just the same, like their policies were not up to date and they just did everything the way that she [sister] wanted to do it. It’s just how things were done. But nothing new was ever done”* (P13 Interview 1 Line 19)

*“People just said ‘we’ve always done it that way, why on earth we would change it? It wouldn’t work any better!’. You just have to get on with it”* (P9 Interview 1 Line 22)

*“You come up with a lot of barriers from people, cos [sic] automatically a lot of people don’t like change, particularly if they [ward management] say you can’t do something no more [sic] they [staff] go [sic] ‘why shouldn’t I do it that way, just get on with it, it’s easier this way’”* (P19 Interview 1 Line 56)

These participants were articulating beliefs that they were not able to change practice due to established routines and rituals in the workplace. These findings highlight the powerful influence of professional socialisation and peer acceptability, including poor role modelling, which can cause individuals to carry out unacceptable behaviours or actions; adopting ritualised practice, traditional views and ideologies in order to fit in (Bahn, 2001; Mackintosh, 2006; Houghton, 2014). Bradbury-Jones et al., (2007) discovered that when student nurses feel they lack a voice, they silently acquiesce and are unable to challenge practice even though they sense something was wrong. Bradbury-Jones et al., (2007) and Levett-Jones et al., (2009b) suggested that student nurses felt disempowered if they witnessed poor practice and were concerned about being compliant with unacceptable nursing practices. Student nurses see conformity as a way to improve their chance of inclusion thus reducing their risk of rejection and this is more common in students who feel less secure of their place in the nursing team. (Levett-Jones & Lathlean, 2009b).

When I asked Participant 19 to tell me more about their experiences, they went on to describe how they could identify areas for service improvement as a student nurse, but had concerns that as a registered nurse they may lose the ability to explore options for improvements and ‘slip’ into established routines of the area they work in:

*“As a student you can see that things are not happening but my concern is that once qualified you might slip into the role of doing everything as they [colleagues] say you are supposed to and you are not even looking outside of the box or to change things”* (P19 Interview 1 Line 60)

When asked for clarification on this, what did this mean to them? they replied:

*“I know what to look for and I won’t just accept things as they are”* (P19 Interview 1 Line 62)

This finding reflects Luanaigh (2015) who found that student nurses are able to distinguish between good and bad nursing practice and when staff demonstrate behaviours that students do not consider appropriate or good, the students actively choose not to repeat those behaviours. This is consistent with Bandura (1971b) who found that behaviours, which are frowned upon, deter individuals from modelling if it breaches their moral principles or is socially unacceptable.

Participants when they became registered nurses, also discussed being aware of routines and rituals in nursing practice. These participants described how they were aware of conforming to existing routines in their clinical environment:

*“Just being on the unit for a while and just getting used to a normal kind of way of doing things and getting into little routines”* (P16 Interview 2 Line 22)

*“I think people get a bit complacent about things, it’s easy just to slip into the routine. I think it is a culture thing, it’s like, ‘We have always done it that way, it works for us’”* (P2 Interview 2 Line 37)

These comments reflect Kelly (1996) who discovered that newly registered nurses often experience pressure to conform to ward routines. Francis (2013) highlighted the challenges in altering a conformist culture in nursing where social or peer acceptability can result in individuals carrying out unacceptable behaviours or actions (Bahn, 2001). Nevertheless, several participants recognised that accepting routine and ritual could be ‘detrimental’ (P4) and patient care may not be ‘best practice’ (P2).

*“If you are stuck in your ways and set in a certain pattern you are not always going to meet everybody’s needs and it could be detrimental to patients” (P4 Interview 2 Line 41)*

*“If you don’t look at how you can improve your services, you don’t improve things for your patients. There is not going to be any advances, you are not going to use any evidenced based practice” (P2 Interview 2 Line 40)*

*“I don’t know if they [staff] think this is easy or this is just the way we do it, but that way can be, maybe a danger, you don’t move forward in practice” (P14 Interview 2 Line 23)*

This supports Rytterström et al., (2011) who found that the act of caring is so taken for granted that nurses do not reflect on whether this actually leads to good patient care. As such, it is possible to have non-caring routines that nursing staff feel are completely appropriate (Rytterström et al., 2011).

When asked for further clarification, these participants went on to suggest that:

*“If we were not doing that [service improvement] they would just be doing these old practices and they [other staff] would be passing them on to us and we would be doing that. You would never be getting to where it is best practice. I think if you don’t look for how you can improve your service and how, things like link nurses and nurses who can go off and find out new information, you don’t get better at anything” (P2 Interview 2 Line 48)*

*“The risks if you don’t do it [service improvement]. Things that are not working either for the team or the patient, you can always improve all the time. I don’t know if they [staff] think this is easy or this is just the way we do it, but that way can be, maybe a danger, you don’t move forward in practice” (P14 Interview 2 Line 28)*

These comments reflect Ashforth & Saks (1996) who found that when nurses adopt existing values and beliefs of the clinical area; this hinders changes in nursing practice and service

innovation. Rytterström et al., (2011) suggested that rather than allow current practice to become routine, service improvement is a means to review and develop safe and effective practice. The participants in this study recognised that they would have to challenge existing routines and rituals in order to make service improvements. As nurses develop their views and experiences of service improvement, this leads to a positive cultural transformation where sustaining improvements in healthcare becomes part of the routine (Morrow et al., 2012; Shafer and Aziz, 2013).

#### ***6.5.5 Summary of theme Four***

Theme Four has demonstrated that the participants experienced challenges with changing practice through service improvement. During their professional transformation from student to registered nurse, the participants demonstrated a developing resilience. Despite the challenges of implementing service improvement, they felt they had an important role to contribute to service improvement and would persevere with making changes. It was apparent that mentors and staff, who supported the participants in making service improvements, played an important part in their experiences. It was evident in the findings that the participants became empowered through support from mentors, colleagues and their ward manager; who was identified as being significant in changing nursing practice through service improvements.

### **6.6 Initial theoretical analysis: Summary of the four key themes**

The findings have highlighted the experiences of participants from student to registered nurse in service improvements in nursing. Using van Manen's (1990) activities of data analysis, the phenomena of service improvement, as lived by the participants has been explored within the context of nursing. Reflection on the essential themes that characterise the phenomenon of service improvement in nursing, has been presented in this chapter as the four key themes and sub-themes, which emerged from the findings. The phenomena

have been described by using verbatim quotes to ensure the participant voice has been heard.

In Theme One, the participants demonstrated an understanding of service improvement within a nursing context and could identify the need for service improvements. The participants understanding of service improvement developed as they professionally transformed from student to registered nurse through their ongoing interactions, learning and experiences of the phenomenon in nursing.

Theme Two illustrated how participants when student nurses, felt they did not fit in and lacked a sense of belonging. However, this perception changed when the participants became registered nurses and were working in their clinical teams. Fitting in and having supportive relationships was important. Through their social and learning interactions with mentors and colleagues, the participants reflected on their professional transformation as registered nurses. These factors were instrumental in the participants developing confidence and helped them become empowered and build resilience when making service improvements.

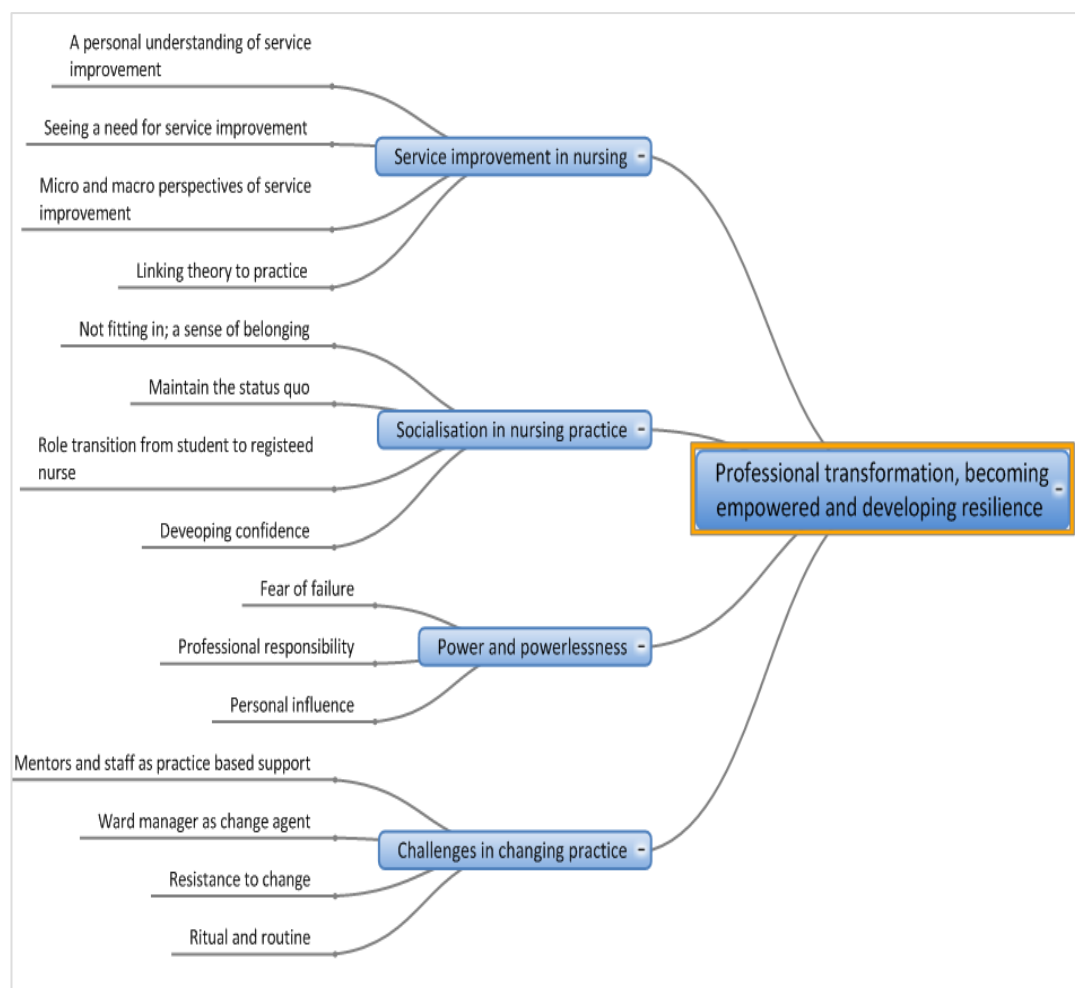
Theme Three findings provided evidence that the participants felt powerless in making service improvements when student nurses. However, the participants demonstrated professional transformation when their role changed from student to registered nurse. The participants described a change in status, power, responsibility and authority as registered nurses. The participants discussed becoming empowered to change practice through service improvements. It was evident that they were developing resilience in how they would persevere in making improvements; despite challenges and resistance they may face.

Theme Four illustrated how participants experienced challenges in changing practice through service improvements, as both student and registered nurses. It was evident that relationships with mentors and colleagues were important and participants valued positive

relationships, social interaction and supportive feedback. As the participants professionally transformed they discussed how, despite challenges faced when making service improvements, they would persevere, as they believed they had an important role to play. The importance of the ward manager in empowering the participants to make service improvements through their support and delegated authority was evident.

The analysis of the findings has maintained a strong orientation to the phenomena of service improvement in nursing (van Manen, 1990). Figure 23 illustrates the four key themes that emerged from the findings and initial theoretical analysis:

**Figure 23 Initial theoretical developments emerging from the four key themes**



The four key themes and related sub-themes have been presented using appropriate literature to inform the analysis of the findings. This approach to assimilating findings with relevant literature is congruent with hermeneutic phenomenology (Draucker, 1999). Through initial theoretical analysis of each key theme, there is evidence that the participants underwent three processes of professional transformation, developing resilience and becoming empowered in making service improvements. This initial theoretical analysis gives a valuable insight into the participants' lived experiences of service improvements in nursing.

## **6.7 Chapter conclusion**

This chapter has presented the findings, using verbatim quotes in order to illuminate the experiences of participants from student to registered nurses in making service improvements in nursing. Four key themes were identified and have been discussed in context of existing literature to highlight similarities and differences in the findings. Data analysis has occurred using van Manen's (1990) activities of analysis. Initial theoretical analysis has shown that the participants underwent processes of professional transformation, developing resilience and becoming empowered. In the following discussion chapter, the findings are synthesised in the final stage of data analysis. The findings are balanced by considering the parts and the whole (van Manen 1990). Through this process, deeper interpretation and analysis of the findings provides a new understanding of how the participants made service improvements in nursing.

## **Chapter 7 Discussion ‘A New Understanding of Service Improvement Enablement’**

### **7.1 Introduction to chapter**

The previous chapter presented the findings of service improvement experiences from student to registered nurse. This chapter expands on the initial theoretical analysis and perspectives in Chapter 6; deepening the analysis.

The chapter is organised in three sections, structuring the discussion in a systematic way in order to illustrate this deeper analysis and hermeneutic interpretation. Firstly, the research aim and objectives are revisited. The conceptual framework and original theories of power, social constructivism, professional development and social and adult learning theories are discussed as a lens through which I was able to illustrate my interpretation of the findings.

Next, the emerging processes of professional transformation, becoming empowered and developing resilience are explored. It was evident in the findings that in order to go through these processes, the participants adapted their behaviours.

A discussion of positive adaptive behaviours that the participants used to enable them to make service improvements follows. The final section of this chapter expands on this discussion and culminates in the presentation of an original model, providing a new understanding of how student and registered nurses become enabled in making service improvements in nursing.

### **7.2 Revisiting the research aim, objectives and questions**

The overarching aim of this study was to provide:

*‘An understanding of the lived experiences in making service improvements in nursing from student to newly registered nurses’*



In order to achieve this, the following research objectives were identified:

- To investigate the lived experiences of nursing students in service improvement after they had completed a module on service improvement in university and clinical practice.
- To identify and explore factors, which influence nursing student's learning and experiences in service improvement practice.
- To understand how student nurses, adapt to being newly registered nurses in making service improvements in nursing practice.
- To identify strategies and behaviours which student and newly registered nurses utilise in order to make service improvements in nursing practice.
- Develop a new model of understanding how nurses make service improvements in nursing practice.

In order to meet these objectives, the following research questions were posed:

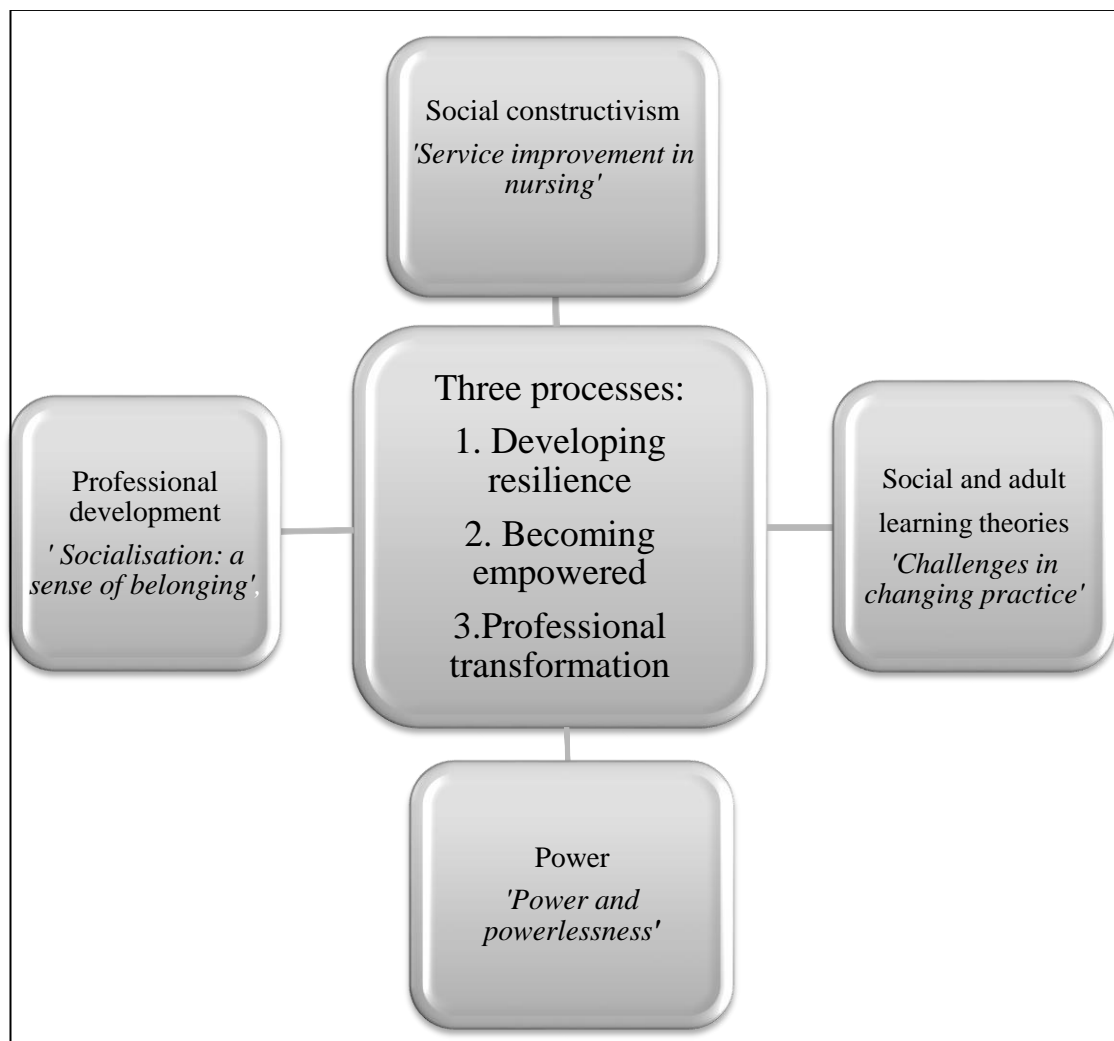
1. *What are student nurse's experiences of service improvement in education and its application in clinical practice?*
2. *What are newly registered nurse's experiences of service improvement in clinical practice?*

### **7.3 Reflection on the conceptual framework**

As discussed in Chapter 3, the conceptual framework provided a theoretical lens through which to view the participants' experiences of service improvement in nursing from student to registered nurse. Social constructivism, social and adult learning theory, power and professional development formed the basis of the conceptual framework, which informed analysis of findings in this study. It was evident that these theoretical concepts were not isolated; rather there were commonalities across the findings of the key themes and sub-themes.

Initial theoretical analysis illustrated the participants underwent processes of professional transformation, developing resilience and becoming empowered as they made the transition from student to registered nurse. Figure 24 illustrates the key themes that emerged from the initial theoretical analysis of findings and how the three processes and are linked to the conceptual framework:

**Figure 24 Conceptual framework, key themes and initial theoretical analysis**



The next section of this chapter discusses each of the three processes that the participants underwent in turn.

## **7.4 Discussion: three key processes**

### ***7.4.1 Key process 1: Professional transformation***

The findings suggest the participants underwent a process of professional transformation as they made the transition from student to registered nurse. These findings can be viewed from the theoretical lens of professional development and social and adult learning theories, which are closely related to social constructivism (Brandon & All, 2010).

In nursing, professional development occurs through education and on-going development of skills in clinical practice (Pennbrant et al., 2013). Benner (1984) identified how nurses transform from novice to expert during their professional careers. The participants as student nurses were novices in making service improvements in nursing. They demonstrated a theoretical understanding of service improvements but had limited experience of this in their nursing practice. The participants discussed service improvement at micro level; limited to individual, patient-centred, small-scale improvements, within their personal sphere of influence.

A process of professional transformation was evident as the participants reflected on their student experiences of service improvement and integrated new knowledge, understanding and practice as they moved along the trajectory from student to registered nurse. These findings correspond with Benner (1984) who found that acquisition of knowledge and skills occur over time, through both experience and theoretical knowledge. The participants as registered nurses, had expanded their understanding to a macro perspective of service improvement. This expansion included awareness of wider benefits for the team and NHS organisation, displaying a strategic understanding of the importance of improving services and delivering high quality patient care.

This supports other research that has suggested that through professional development, nurses develop awareness of aims from wider perspectives and see themselves contributing to these aims, as they become competent practitioners (Benner, 1984).

The social aspect of learning that became evident in the findings of this study is consistent with adult and social learning theories, which espouse the importance of the social context of learning, and how this enhances the efficacy of learning (Bandura, 1971a; Kolb, 1984; Knowles, 1997). Kolb (1984) identified four stages of learning, commencing with concrete experiences, reflective observation, abstract conceptualisation and active experimentation. Learning occurs through recognising concrete experiences where new knowledge is created through personal and environmental interactions. All the participants described having concrete experiences of service improvements, where they had experienced this in their nursing practice. Reflective observation concerns learning from experiences, including discussions of why and how things occurred. The participants reflected on their service improvement experiences, describing discourse and interactions they had with mentors and colleagues. This is consistent with Laschinger (1987) who suggested that new knowledge is constantly being created through social interactions. The participants, discussed resistance and barriers to service improvement and reflected on how they would persevere, as service improvement is integral to their role. The participants removed their own feelings from the situation and considered the risks and merits of service improvement. This is evidence of what Kolb (1984) describes as abstract conceptualisation, where learners use logic and ideas rather than feelings to understand situations and problems. The participants described different approaches they would use to identify, share ideas and gauge support for service improvements, depending on the power and authority they felt they had at that time. This corresponds to active experimentation (Kolb, 1984), where learners test theories to make predictions and to act. Through seeking colleagues support and advice, the participants were testing their suggestions for service improvements and planning how to make changes happen.

These findings provide evidence that participant professional transformation occurred through positive socialisation and learning experiences. The participants valued supportive staff and positive interactions with colleagues and ward managers when making suggestions for service improvements, describing these colleagues as positive role models. Bandura's (1971a) social learning theory identifies learning that occurs through observing effective role models. The findings in this study highlighted how participants reflected on the positive influence some staff had on their learning and appeared to be modelling their own behaviours based on these experiences. Bandura (1971a) found that learners model their behaviours through being self-reflective and being self-reactive.

#### ***7.4.2 Key Process 2: Becoming empowered***

Power, social and adult learning theories and social constructivism provide a lens through which to view the process of becoming empowered. Social rules are permeated with power and this is intrinsically linked to social constructivism within nursing (Potter, 2003). Nursing is a social working environment and it is therefore important to consider the impact of power on nursing practice (Bradbury-Jones et al., 2008).

The findings in this study provide evidence that positive socialisation, fitting into the team and having a sense of belonging were key features in how the participants became empowered to make service improvements in nursing. Bandura's (1971a) social learning theory acknowledges the importance of the social learning environment and the social interactions through which learning occurs (Bahn, 2001). As student nurses, the participants who described fitting in and having positive experiences of socialisation, suggested they were empowered by mentors and colleagues in making service improvements. The findings in my study correspond with Bradbury-Jones et al., (2011) who found that nursing student's perceptions of being valued as learners and as part of the team increased their sense of empowerment. In my study, those participants who had supportive mentors, appeared to admire the characteristics that these staff demonstrated

and viewed them as role models. Bahn (2001) found that mentors who were positive role models had a positive influence on student learning which in turn helps to empower learners to improve their own practice (Bandura, 2002).

Some participants demonstrated that as student nurses, they found their ability to make service improvements was hindered by a lack of power. This finding is consistent with a poststructuralist perspective of power, where power is viewed from a bottom up and a top down approach (Foucault, 1995). Participants suggested this was due to a hierarchical environment where they held a low status (bottom) as a student nurse. Participants considered power resided with mentors, ward managers and colleagues who held a higher status (top). Power comprises of socially constructed systems that reproduce and sustain power imbalanced relationships (Potter, 2003; Gray & Thomas, 2005). In this study, participants who were not able to make service improvements, described how some mentors and colleagues resisted their attempts to make changes, which the participants linked to their own lack of status and power as student nurses. This finding is consistent with Kuokkanen & Leino-Kilpi, (2000) who found that some individuals are restricted in having the power to be able to act as a result of power structures containing hierarchy and authority.

As registered nurses, the participants experienced a change in their status, recognising that their power was greater than when they were student nurses. The participants described a perception of having the power as registered nurses to be able to make improvements. As the participants transformed in terms of status, hierarchy and authority, their perception of having the power to make service improvements increased. This finding correlates with Kuokkanen & Leino-Kilpi (2000) who found that in nursing power is connected to authority, leadership and hierarchy. An interesting finding in this study was illustrated by the participants, who would seek the ward manager's advice, support and delegated authority to make service improvements if the participants perceived they lacked the

personal influence and power to make changes themselves. This finding is consistent with Foucault (1995) who suggested that power results from knowledge and discourse. If necessary, participants would seek their ward manager's advice, knowledge and agreement; gaining delegated authority and agreement for their suggestions for change. Through this process, the participants were being empowered to make service improvements. These findings support Madden (2007) who found that nurses gained authority through a process of empowerment; a feature that is essential in nursing.

It was apparent that the participants valued sharing ideas and having feedback from other colleagues regarding service improvements. Participants described becoming empowered through feeling part of a wider team and having open forums for discussions and sharing ideas for service improvements. These findings correspond with other studies where nurse empowerment stems from effective communication; having access to information, transferring knowledge and through close personal relationships (Kuokkanen & Katajisto, 2003; Madden, 2007). As registered nurses, the participants gained experience and knowledge of service improvement through practice and interactions and they became more confident about making improvements. This reflects how social support from managers and colleagues positively influences empowerment of nurses (Madden, 2007). This is an important finding, as nurses who feel empowered are more likely to be effective at work and to make proactive efforts aimed at improving current practice (Montani et al., 2015).

#### ***7.4.3 Key process 3: Developing resilience***

The process of developing resilience can be considered through the theoretical lens of social constructivism and social and adult learning theories. The importance of positive socialisation and fitting in to the team was a key feature in how the participants developed resilience. It was evident in the findings that some participants, as student nurses, felt they did not fit in. This appeared to affect their self-confidence, making them feel vulnerable

and unable to make service improvements. Participants described how they adopted strategies to help them integrate into their teams, including the use of casual conversations and offering to help colleagues.

It was evident that the participants were adapting their behaviours and approach in order to fit in and cope with challenges in making service improvements. These findings are consistent with Stephens (2013) who found that student nurses developed resilience through using personal protective factors and strategies in order to cope with challenges faced in nursing practice.

In contrast, the participants who described feeling part of the team as student nurses, suggested that a positive learning environment and having a sense of belonging were contributing factors in them being able to make service improvements. The participants described valuing learning in teams, where positive mentors and supportive colleagues helped them to implement their service improvements ideas. Social constructivism highlights the importance of the learning environment and suggests that opportunities, which encourage knowledge and understanding, are key factors of student success (Kala et al., 2010).

The findings in this study revealed that participants, as registered nurses, felt they did fit in and had a sense of belonging in their working environment. Participants described how they valued being part of a team and had developed positive relationships with colleagues. Nursing is a social environment where knowledge and workplace learning is socially constructed through interactions and relationships among staff working in teams and within organisations (Levett-Jones & Lathlean, 2008; Duane & Satre, 2014). Participants described how they would use discussions with colleagues as a means to gauge support for service improvement ideas. These findings reflect other studies, which found newly registered nurses, benefited from feeling they belong in the social context and developed resilience through building positive relationships at work (Feng & Tsai, 2012; Carlin, 2013;



Luanaigh, 2015). In my study, it was evident that the participants were developing resilience through adopting strategies to cope with challenges, including using effective communication skills, being respectful, rationalising their suggestions and using the delegated authority of others in order to make service improvements. These findings are consistent with Feng and Tsai (2012) who found newly registered nurses use different strategies to learn, execute their responsibilities and adapt to workplace demands. Rationalising tasks, procedures and standards of practice are essential to the role as a newly registered nurse (Feng & Tsai, 2012).

Participants also discussed how they would not accept poor practice or routine as being standard nursing practice, describing a personal resolve to make service improvements despite challenges and barriers to change. Through demonstrating perseverance and looking for ways to engage others in service improvements, the participants were developing resilience. Participants identified role transition as a challenging process, where some adapted more quickly than others in making service improvements. Resilience is how individuals manage their reactions to stressors at work (McAllister & Lowe, 2011) and recover from setbacks (Hart et al., 2014). Participants suggested that they developed resilience through using support from colleagues, ward managers and their NHS Trust preceptorship programme which helped them to adapt to the change in their role. This finding is consistent with Feng and Tsai (2012) who found that newly registered nurses develop resilience and the ability to cope with stressful situations by developing their own coping strategies.

This section of the chapter has explored professional transformation, becoming empowered and developing resilience as three processes that the participants underwent, using the conceptual framework to inform the analysis of findings. The next section of this chapter expands on this discussion, through deeper analysis, using the hermeneutic circle and hermeneutic interpretation, as discussed earlier in this thesis. Hermeneutic interpretation

helps to explain meanings and assumptions in the findings that the participants may have difficulty conveying themselves (Crotty, 1998).

### **7.5 New insights: Towards an understanding of self-efficacy in service improvement enablement**

The final activity of van Manen's (1990) data analysis, balances the research context by considering the 'parts' and the 'whole'. The initial theoretical development, which emerged from the findings, illustrated that participants experienced processes of professional transformation, developing resilience and becoming empowered.

However, in order for these processes to occur, the participants were revealing behaviours, which they had developed in response to their learning and experiences of service improvement in nursing. Through undergoing the processes of professional transformation, developing resilience and becoming empowered, it was evident that the participants were developing 'new positive adaptive behaviours', in order to improve their practice and make service improvements in nursing. This is consistent with Bandura (2002) who found that effective problem solvers are motivated to improve their own practice.

From a deeper analysis of the findings, using the hermeneutic circle, it was evident that the participants had developed seven, new positive adaptive behaviours. These behaviours formed the foundation for the processes of professional transformation, becoming empowered and developing resilience. Figure 25 illustrates seven positive adaptive behaviours of improvement which became evident through deeper analysis of the findings.

Figure 25 Seven positive adaptive behaviours of improvement



The positive adaptive behaviours, which the participants developed, can be illustrated by drawing on the key concepts within Bandura's (1997a) Theory of Self-efficacy. Bandura (1995) describes self-efficacy as an individual's belief in their capability to organise and execute the actions required to manage future situations (Bandura, 1995). Bandura (1997 a, b) found that individuals use four sources of information in order to determine self-efficacy.

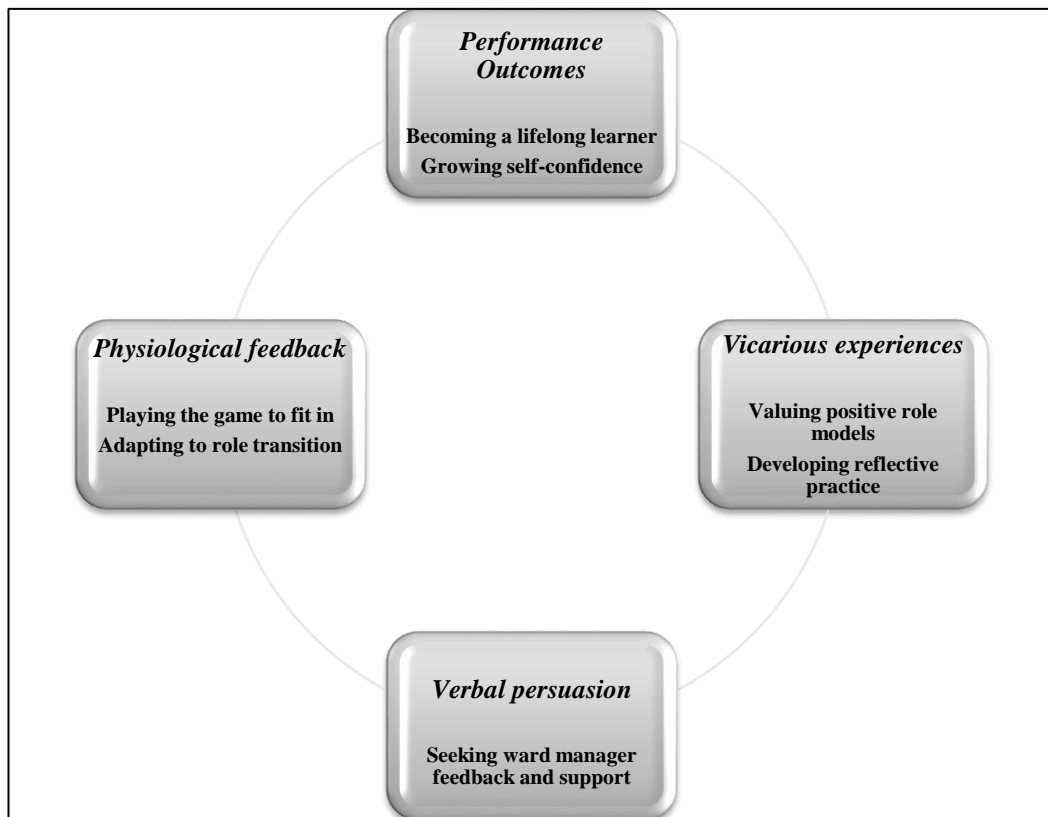
The four sources of information, which Bandura (1997 a, b) describes, are:

- *Performance outcomes*: this involves the individual being able to carry out behaviours and be successful in their performance.
- *Vicarious experiences*: this is where modelling occurs as the individual observes another's performance. Individuals learn through observing and emulating effective role models.
- *Physiological feedback*: this involves feedback occurring through physiological and affective states and feelings.
- *Verbal persuasion*: this is where learning occurs through dialogue and effective feedback with others.

The sources of information establish whether the individual believes they are capable of accomplishing specific tasks. They are important in improving an individual's self-efficacy (Bandura, 1997 b) and are essential for effective performance (Ferrand et al., 2006). In this study, this relates to the participant's belief in their ability to make service improvements in nursing, from student to registered nurse.

Figure 26 illustrates the new positive adaptive behaviours that the participants developed in order to make service improvements, linked to the four sources of self-efficacy. Each of which, will be discussed in turn:

**Figure 26 Sources of information applied to positive adaptive behaviours in service improvement**



## **7.6 Performance outcomes**

Through performance outcomes, it was apparent the participants engaged in service improvements in nursing and were able to make changes in practice. The participants reflected on lifelong learning and growing self-confidence in their ability to make improvements.

### **7.6.1 *Becoming a lifelong learner***

It was evident that the participants, as both student and registered nurses, recognised the importance of lifelong learning. Lifelong learning is integral to being a registered nurse and is a prerequisite to on-going professional development (Benner, 1984; NMC, 2015). The participants described an awareness and desire to continue to learn and build on their

previous service improvement knowledge and experiences. This supports Davis et al., (2014) who found that lifelong learning is a mechanism that nurses use over a period of time. Bandura (1995) suggested that by being responsible for their learning, learners are developing self-efficacy. Participants demonstrated an intrinsic motivation to learn and were able to link lifelong learning and on-going professional development with being able to make service improvements. Participants accessed in-house education on service improvement during their preceptorship, which they found beneficial to building their confidence in making improvements. Through lifelong learning nurses develop clinical thinking ability, clinical skills, courage, and optimism and grow in self-confidence (Eason, 2010; Davis et al., 2014).

Lifelong learning is associated with the concept of professional transformation and aligns with Benner's (1984) Novice to Expert theory of professional development, which nurses' undergo during their professional careers. As student nurses, the participants were novices in relation to service improvements in nursing. Benner (1984) suggested that novices are new to the environment, with little knowledge or experience in situations where they are expected to perform. Although the participants had an understanding of the concept and theory of service improvement, their experiences in practice were limited. As student nurses, the participants focussed on a micro perspective, concentrating on small scale, individual and patient-focussed service improvements, which were achievable within their sphere of influence. For example, Participant 2 (Interview 1) described giving patients extra dairy cream with their diet in order to increase calorific intake, as a simple small-scale improvement.

A change occurred for the participants as registered nurses. They discussed experiences and knowledge in service improvement, which they had expanded. Some participants had undertaken further learning during their preceptorship programme and demonstrated engagement in ongoing learning. Through this learning the participants were undergoing a

process of professional transformation to an advanced beginner or competent level (Benner 1984), where they described being actively engaged in making service improvements. Several participants described a macro perspective of service improvement, focussing on service improvements that had benefits for patients and colleagues. Benner (1984) found advanced beginners have sufficient real life experiences to demonstrate acceptable performance. Other participants demonstrated professional transformation at a competent level where they demonstrated awareness of the strategic importance of service improvement for their department and NHS Trust. For example, Participant 12 (Interview 2) described service improvement as a quality measure for their NHS Trust, reflecting in the Trust's quality ratings. This finding is consistent with Benner (1984) who found that as nurses become competent, they become aware of organisational aims at a wider perspective.

#### ***7.6.2 Growing self-confidence***

Self-confidence is linked to self-efficacy and reflects to a person's confidence in his or her own ability to perform (Bandura, 1997 a; Potter & Perry, 2001). Self-confidence in nursing is the belief in one's abilities to accomplish a goal or task (Potter & Perry, 2001). There was evidence that lack of support from mentors and colleagues had a negative impact on the participant's confidence and ability to make service improvements. However, the majority of participants described a growing confidence in their ability to make service improvements, which was enhanced through support from mentors and colleagues. This finding is consistent with Chesser-Smyth and Long, (2013) who found that student nurses developed self-confidence through clinical practice which was encouraged by positive mentoring experiences, peer support and being successful in practice.

As registered nurses, participants described a change of status and were aware of their personal influence and responsibility in making service improvements. Madden (2007) found that when nurses have power over decisions; they experience increased self-esteem

and increased self-confidence. Participants described a growing self-belief in making improvements, overcoming challenges, reflecting on their experiences and were confident about making suggestions for change. This finding corresponds with Chesser-Smyth and Long (2013) who found that successful performance in clinical practice was the most influential source of self-efficacy. Knowles (1978) suggested that adult learners develop self-confidence and exhibit learning through problem solving, reflection, participation and experiential learning. It was evident that the participants demonstrated a growing self-confidence in their determination not to accept routine or poor practice. Self-confidence underpins a nurse's competence and is closely linked to the concepts of confidence, determination, empowerment and self-efficacy (Dyer & McGuinness, 1996; Crooks et al., 2005).

One participant discussed how their ward manager provided a safe environment to where they could express their ideas and this was important for them developing confidence to make service improvements. When experienced staff provide safe environments for novices, where they can share their experiences and ideas, this helps the novice consolidate their practice (Cope, Cuthbertson, & Stoddart, 2000).

## **7.7 Vicarious experiences**

The participants demonstrated developing self-efficacy through vicarious experiences and by observing other people's performances.

### ***7.7.1 Valuing positive role models***

It was evident positive role models were a key feature in how participants developed self-efficacy in making service improvements. These findings are consistent with other studies which found that student nurses developed self-confidence through clinical practice, supported by positive mentoring experiences and being successful in practice (Bahn, 2001; Chesser-Smyth & Long, 2013). Houghton (2014) found that role modelling is central to



workplace socialisation in nursing and occurs through mentorship which helps students fit in and develop the skills necessary for professional practice. Participants used positive terms when describing mentors, they perceived as positive role models. Bahn (2001) found mentors who were role models had a positive influence on student learning and self-efficacy. It was evident that those participants, who were supported by positive mentors, were more successful in making service improvements.

As registered nurses, participants continued to value colleagues whom they perceived were positive role models and appeared to emulate their behaviours. Participants described growing confidence and self-belief in making service improvements through working with positive role models who offered support, feedback and facilitated them feeling part of the team. These findings are consistent with other studies which found that positive role models raise self-confidence in learners through effective teamwork, supervision, preceptorship and facilitating learning opportunities (Bandura 1997a; Chesser-Smyth & Long, 2012; Houghton, 2014). The participants were adapting their behaviours and modelling through their observations of positive role models. Modelling helps empower individuals to develop personal values that motivate their own improvement behaviours and contributes to self-efficacy (Bandura, 1997a; Bandura, 1999; Bandura 2000). The participants discussed appreciating relationships with colleagues in their team who they would seek for their opinions and feedback on service improvements.

Bandura (1999) found an individual's self-efficacy is increased by working with:

*"A network of reciprocally interacting influences"* (Bandura, 1999, p. 169)

### ***7.7.2 Developing reflective practice***

Participants reflected on their experiences in service improvements in nursing. Reflective practice bridges the gap between theory and practice and facilitates development of new knowledge (Hatlevik, 2012). The participants as student nurses, reflected on their

experiences and interactions with colleagues, identified challenges faced during service improvement and discussed strategies they adopted in order to make service improvements. These findings correlate with other studies, which found that reflection facilitates the development of resilience in student nurses (Jackson et al., 2007; Thomas & Revell, 2016).

As registered nurses, participants continued to reflect on their previous experiences and their current understanding, knowledge and skills in service improvement. The participants reflected on their experiences as students and compared this to their current practice, integrating new knowledge and understanding of service improvement.

This evidences reflection occurring both in and on action (Schön, 1983). The participants reflected on changes in their experiences of service improvements and adopted new behaviours to cope with challenges faced. This supports Thomas & Revell (2016) who found that newly registered nurses assimilate inconsistencies between their perceived role and the reality of being a professional nurse through reflection. The participants used reflection as a means of rationalising and understanding resistance to change through service improvements. Hodges, Keely, & Troyan (2008) found that newly registered nurses develop resilience through using reflective knowledge, self-reflection and self-protection. By being self-reflective individuals are empowered to improve their own behaviours (Bandura, 2002).

## **7.8 Physiological feedback**

Bandura (1997a) suggests individuals sense feelings in their bodies that are linked to emotional arousal. This physiological feedback has an influence on an individual's belief of self-efficacy. It was evident in the findings that feelings had an impact on how the participants experienced service improvements in nursing.

### ***7.8.1 Playing the game to fit in***

Participants described feelings of fitting and belonging as means of physiological feedback both as student and as registered nurses. The concept of belonging and fitting in appeared to be important in how the participants developed self-efficacy. Maslow's (1954) hierarchy of needs identifies an individual's survival or physiological basic needs including air, food, water, clothing and shelter. Higher needs include safety, security, love, belonging, self-esteem and cumulating in self-actualisation. Belongingness is described as having social contact with others, acceptance and feeling and integral component of the group (Maslow, 1968; Baumeister & Leary, 1995).

Participants as student nurses, described lacking confidence and fearing failure in making service improvements which was linked to their feelings of not fitting or having a sense of belonging. The participants as student nurses, described behaviours which they adopted in order to fit in. They would try to join conversations at lunch times and used previous work and personal stories as mechanisms to start conversations with colleagues. It was apparent some participants introduced the concept of service improvement through casual, non-threatening conversation. Others suggested they made ideas for service improvement appear to be their mentors. These findings correlate with Gollop et al., (2004) who found that student nurses looked for the right 'hook' to gain interest in order to engage others in change and service improvement.

Those participants, who perceived they did fit in as student nurses, reported being more self-confident and had more success in making service improvements than those who felt they did not fit in. These findings correlate with Houghton (2014) who found a relationship between student nurses' feelings of 'fitting in' with their working environment and the level of students' confidence. Levett-Jones et al (2009b) found that self-efficacy was strongly influenced by previous experiences and the degree of belongingness that student nurses experienced while on clinical placements. Participants described engaging with, and

discussing suggestions for service improvements with their mentors and colleagues. This finding supports Levett-Jones et al., (2009a) who found students with high self-efficacy are more confident and capable in engaging with clinicians and in negotiating learning opportunities within placements.

A change occurred when the participants were registered nurses; they felt they fitted in and were integral to their clinical teams. Participants described adapting to their work environment, building relationships with colleagues and understanding the context of their clinical area in relation to the wider organisation.

Participants gave examples of adaptive behaviours they used to integrate into the team, including using diplomacy and communication skills. This finding is consistent with Maben et al., (2006) who found that newly registered nurses become an ‘insider’ in their clinical area by becoming familiar with formal and informal rules and the regulations of the hospital. Feng and Tsai (2012) found that newly registered nurses become part of the team by developing positive relationships with colleagues. Participants described valuing the relationships they had developed with work colleagues and this helped them to make suggestions for improvements. Newly registered nurses benefit from positive socialisation within their organisations and this helps them develop self-efficacy (Houghton, 2014).

### ***7.8.2 Adapting to role transition***

Role transition from student to registered nurse appeared to be a pivotal point in the participant’s experiences in service improvement. Some participants described transition shock (Duchscher 2009), where they found it hard to cope with the competing demands of clinical practice and required learning. These participants reflected on their initial post-registration period and described feeling challenged and overwhelmed. The participants linked transition shock to their workload, competing priorities and the rate of learning required to cope with their new role. This finding corresponds with other studies, which

found role transition from the university to nursing practice is complex and entwined with the values and practices of educational institutions, employers, clinicians and fellow students (Maben et al., 2006; Feng & Tsai, 2012; Hatlevik, 2012).

Some participants discussed challenges to make service improvements during role transition because of the competing demands of practice. This finding is consistent with studies that found challenges for newly registered nurses include a lack of clinical knowledge and confidence in clinical skills, developing working relationships, prioritising workload demands and organisational priorities were (Chang & Hancock, 2003; Schoessler & Waldo, 2006; Duchscher, 2008; Duchscher, 2009; Feng & Tsai, 2012; Hatlevik, 2012). The participants did not perceive service improvement as a priority at this point of their post-registration practice and improvements were described as being small scale or restricted to individual patients. Some participants described feeling overwhelmed by the amount, and rate of learning, needed in order to function as a registered nurse. This correlates with Lauder et al., (2008) who found that those individuals who are ineffective in their performance do so not because they are deficient in skills and knowledge, rather because they lack self-efficacy. Self-efficacy is a construct where low levels of self-efficacy produce avoidance behaviour (Lauder et al., 2008).

Feng and Tsai (2012) found that the speed at which newly registered nurses adapt to their new role is variable. The findings illustrate that other participants adapted more readily during their role transition to being a registered nurse. The participants adapted their behaviours, accepting that they had a responsibility to make service improvements as registered nurses, believing they had a responsibility to provide high quality, patient-centred care. They described how they would face challenges in making improvements rather than accept established nursing routines and rituals, which they considered were less than best practice. This finding correlates with Feng and Tsai (2012) who found that when newly registered nurses experienced difficulties during role transition, they coped with the

challenges because those experiences gave them confidence to provide better care to their patients.

## **7.9 Verbal persuasion**

Verbal persuasion in self-efficacy concerns feedback through dialogue and discussion regarding an individual's performance (Bandura, 1997a). It was apparent that verbal persuasion was a feature recognised by participants as they discussed the importance of feedback and support from mentors, colleagues and ward managers about their service improvement suggestions and ideas. However, verbal persuasion is arguably a weaker source of self-efficacy than performance outcomes; however, verbal persuasion is used extensively because of its ease of use in the working environment (Redmond, 2010).

### ***7.9.1 Seeking ward manager feedback and support***

The participants as both student and registered nurses sought support from their ward manager in making service improvements. The role of the ward manager as a leader and facilitator of change was seen as fundamental in making service improvements. Active engagement at a senior level is a critical component of successful service improvement initiatives (Gollop et al., 2004) and the leadership of the ward manager is a central feature in nurse-led service improvement models (Shafer & Aziz, 2013).

Participants described the ward manager as positive role model who welcomed and supported student learning and fostered a culture of change. The role of the ward manager in facilitating a positive learning environment has been a consistent feature in nursing practice (Orton, 1981; Fretwell, 1982; Ogier, 1986; Welsh & Swann, 2002; McGowan, 2006; Carlin, 2013). As student nurses, participants felt more empowered to make service improvements depending on the amount of support they received from the ward manager. Ward managers who were receptive to their suggestions for service improvements facilitated them to make changes in practice.

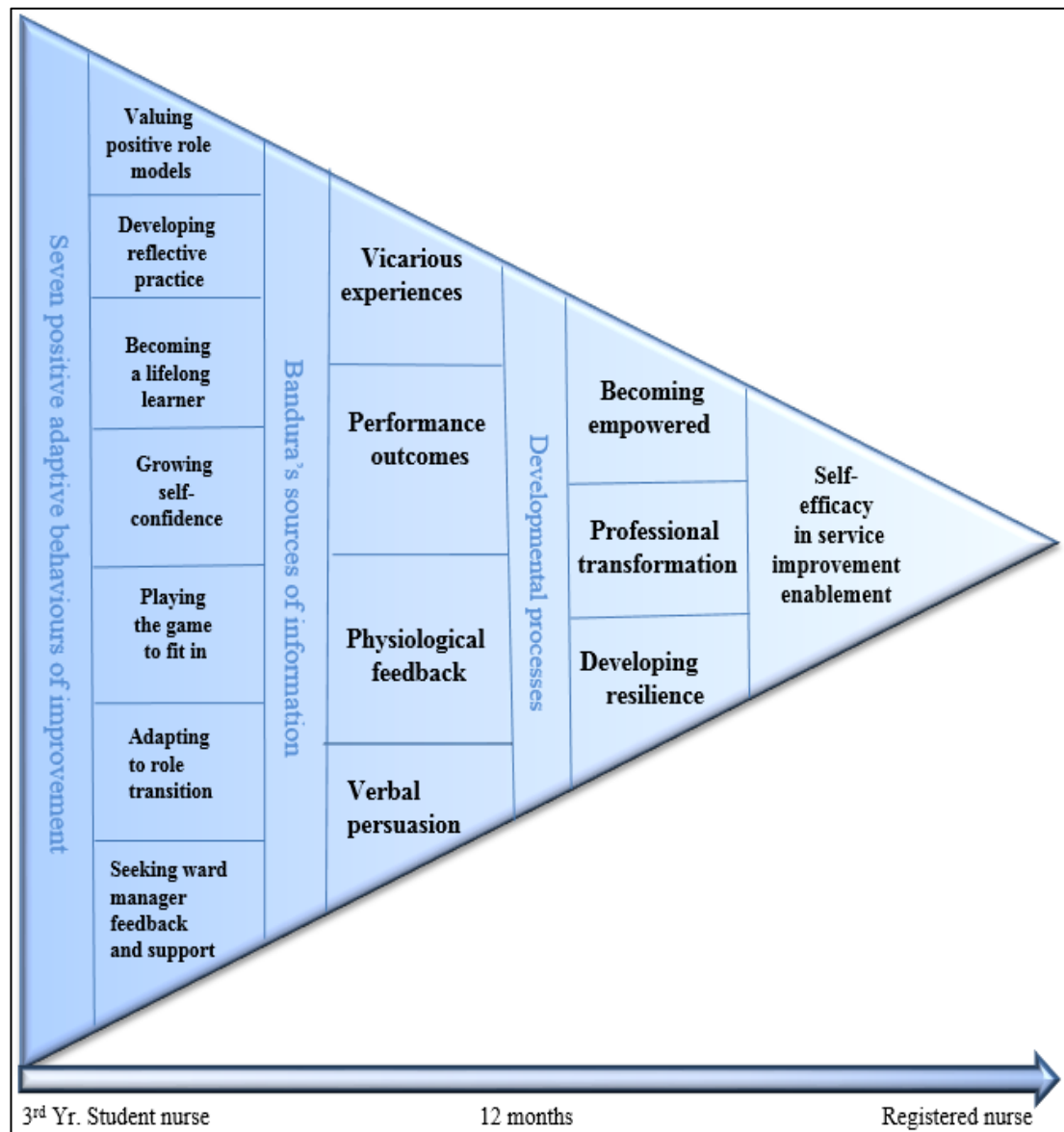
As registered nurses, participants continued to recognise the ward manager as being central in making service improvements. Participants discussed taking their suggestions for change, sharing ideas, seeking support and receiving feedback from their ward manager. Ward managers empower staff through being accessible; giving feedback and by providing resources and support (Madden, 2007). Participants identified the need for strong leadership and management as prerequisites to change practice through service improvements. The ward manager was important in reducing resistance to change and having the authority to implement service improvements. This finding is consistent with Madden (2007) who found that ward managers remove barriers to change, increase commitment to the organisation and empower staff.

Redmond (2010) found credibility has a direct influence on the effectiveness of verbal persuasion and argues the more credible the individual the perceived greater influence. Participants actively sought feedback and support from their ward manager, describing being involved in decisions and feeling valued through this discourse. Nurses, who feel involved in decision-making and valued for their contribution feel more empowered (Faulkner & Laschinger, 2008). Encouragement or discouragement regarding a person's ability and performance is a key feature in how individuals develop self-efficacy (Redmond, 2010). When necessary participants sought deferred authority from the ward manager in order to be empowered to make service improvements. Strong, effective ward managers provide leadership that is integral to empowering staff (Madden, 2007).

#### **7.10 A new explanatory 'Model of Self-efficacy in service improvement enablement'**

Having analysed in depth the participants' lived experiences of service improvement, from student to registered nurse. I have developed a new explanatory model '*Model of Self-efficacy in Service Improvement Enablement*' (Figure 27).

Figure 27 New ‘ Model of Self-efficacy in Service Improvement Enablement’



This new and unique model brings together the positive adaptive behaviours that underpin professional transformation, developing resilience and becoming empowered in making service improvements in nursing. As illustrated, the model explains how nurses adapt along a trajectory from being a third year student to registered nurse, in order to make service improvements in nursing. Data suggested that as the participants progressed along the trajectory, they demonstrated how they acquired and used seven positive adaptive



behaviours; valuing positive role models, developing reflective practice', becoming a lifelong learner, growing in self-confidence, playing the game to fit in, adapting to role transition and seeking ward manager feedback and support. In the course of this positive adaptive behaviour change, participants drew on four sources of information to determine self-efficacy (Bandura, 1997a, b). These include vicarious experiences, performance outcomes, physiological feedback and verbal persuasion. Over the course of the transition period from third year student to registered nurse, this activity culminated in three outcomes related to their lived experience of service improvement and service improvement learning namely, professional transformation, becoming empowered and developing resilience. Although the model is presented as a linear process, the rate of service improvement engagement and development differed between participants; influenced by the context of their learning and practice. However, by the time the participants had made the transition through their preceptorship, they had all achieved a degree of empowerment, resilience and transformation, enabling them to move forward with service improvements in their own work context.

## **7.11 Chapter conclusion**

This chapter was presented in three sections. Firstly, the conceptual framework informing the analysis of findings was revisited. Next, the processes of professional transformation, becoming empowered and developing resilience were discussed. Further analysis of findings illustrated how the participants became enabled in making service improvements through developing positive adaptive behaviours which have been informed by Bandura's (1997a) four sources of self-efficacy. Finally, a new and unique '*Model of Self-efficacy in Service Improvement Enablement*' has been presented as a way to explain how student and registered nurses are able to make service improvements in nursing.

The following chapter will conclude this thesis. It will summarise how this thesis adds to the understanding and knowledge regarding how student and newly registered nurses

engage in making service improvements in nursing. It concludes by making recommendations for future nurse education, practice, research and Trust policy.

## **Chapter 8 Conclusion to thesis**

### **8.1 Introduction to chapter**

This chapter concludes this thesis. The research, on which this thesis is based, set out to explore the lived experiences from student to registered nurse of service improvements in nursing. This chapter highlights the unique contribution that this thesis provides in relation to the overall aim of the study, which was to understand how student nurses and registered nurses make service improvements in nursing. Potential limitations of this study are acknowledged. I also provide a reflexive account of my learning during the research process. Finally, the chapter concludes with recommendations for future pre-registration nurse education, nursing practice and research.

### **8.2 Overall summary and methodological fit**

The focus of this study centred on gaining an understanding of the experiences of service improvement from student to registered nurse. As discussed in Chapter 1, the focus of this study stemmed from my desire to develop a comprehensive understanding of the phenomena of service improvement in nursing and was informed by my personal worldview. My interest coincided with a range of service improvement initiatives and policies introduced by the UK government as way to improve healthcare provision and quality of patient care. Recently service improvement learning has been embedded into pre-registration nursing programmes as a way to promote service improvement in nursing practice. Despite these service improvement initiatives, there is little research demonstrating their effectiveness in improving patient care and services. Reflecting on my experiences and practice, I sought to understand the complexities of making of service improvement in nursing. My desire was to contribute to filling the gap in the existing body of research and to inform future nurse education, practice and research in order to enhance service improvement in nursing practice.

The literature review presented in Chapter 2 was an ongoing process, expanding after both phases of data collection. This approach of assimilating relevant literature with the findings of the research as an iterative process, is commensurate with hermeneutic phenomenology. As the literature search identified, there was a scarcity of empirical research exploring the perceptions or experiences of service improvements in nursing from student to registered nurse. In particular, there was no research, which articulated an understanding of how student and registered nurses make service improvements in nursing. Nor was there any research explaining how student nurse experiences and learning of service improvement in nursing, translates to their post registration practice.

Recognition of this lack of research, reinforced my motivation for this study and resulted in the development of my research aim, objectives and questions, which were introduced in Chapter 1 and are reiterated below:

*‘An understanding of the lived experiences in making service improvements in nursing from student to newly registered nurses’.*

My research objectives were to:

- To investigate the lived experiences of nursing students in service improvement after they had completed a module on service improvement in university and clinical practice.
- To identify and explore factors, which influence nursing student’s learning and experiences in service improvement practice.
- To understand how student nurses, adapt to being newly registered nurses in making service improvements in nursing practice.
- To identify strategies and behaviours which student and newly registered nurses utilise in order to make service improvements in nursing practice.

- Develop a new model of understanding how nurses make service improvements in nursing practice.

In order to meet the aim and objectives of this study, the following research questions were developed:

1. *What are student nurses' experiences of service improvement in education and its application in clinical practice?*
2. *What are newly registered nurses' experiences of service improvement in clinical practice?*

The research questions, highlighted above, centred my study on gaining an understanding of the experiences of service improvement in nursing, through the lived experiences of participants who had personal experiences of this phenomena. The research questions were informed by the gap in existing empirical research and knowledge, as well as being influenced by my own world view. Though my own experiences of service improvement in nursing, both as a nurse and educationalist, I had my own views, perceptions, values and ideas on what service improvement is. This acknowledgement of my own perceptions and experiences led to an interpretivist methodology being selected for this study. In chapter 3, a social constructivist framework, was considered as the theoretical influence underpinning my study, recognising that individuals give meaning to reality, events and phenomena through processes of social interaction (Denzin & Lincoln, 2005). Commensurate with this theoretical influence, as discussed in Chapter 4, hermeneutic phenomenology was selected as this allowed the participants to provide rich descriptions of their lived experiences of service improvement in nursing. Lived experience is understood through how an individual encounters a situation in respect of their own context, interest, background and purpose (Benner, 1984; Crotty, 1996).

The hermeneutic circle supported interpretation and analysis of the findings, which was informed by my own knowledge and experiences of service improvement in nursing. This methodological approach recognised and acknowledged my own fore-having, fore-sight and fore-conception in order to understand and interpret the meaning of a phenomenon (Converse, 2012). van Manen's (1990) activities of data analysis facilitated my analysis of findings to allow a new understanding and insight into how the participants developed in order to make service improvements in nursing.

As discussed in chapter 5, twenty participants were purposively sampled from the third year of an adult pre-registration nursing programme. Data collection occurred twice, once when the participants were students and again 12 months later when the same participants were registered nurses. The individual semi-structured interviews, achieved the objective of investigating experiences of service improvement in nursing from student to registered nurse. In chapter 6, rich descriptions of the participant's lived experiences in learning and practice of service improvement in nursing were presented. Using verbatim quotes ensured the participants voices were heard and the orientation to the phenomena remained strong.

Through further hermeneutic interpretation and deeper analysis of the findings, I was able to achieve my final research objective. In chapter 7, I discussed the findings and the final stage of data analysis, considering the parts and the whole (van Manen, 1990). This allowed a new and unique model to be presented, which explains how the participants became enabled to make service improvements in nursing.

### **8.3 New 'Model of self-efficacy in Service Improvement Enablement'**

Through analysis of the data, four key themes emerged from the findings; *Service improvement in nursing*, *Socialisation in nursing practice*, *Power and powerlessness* and *Challenges in changing practice*. These themes have been presented in chapter 6, using verbatim quotes to ensure the participant voice was heard.

From initial theoretical analysis, three developmental processes occurred for participants as they progressed along a trajectory from student to registered nurse; *professional transformation, becoming empowered* and *developing resilience*. These processes were informed by the underpinning theoretical influences of this thesis and in respect of the research aim and questions. Through further in-depth analysis, it was evident that in order to achieve these developmental processes, the participants acquired and used seven positive adaptive behaviours. These behaviours were conceptualised using Bandura's (1997a) four sources of self-efficacy and combined under an overarching new '*Model of Self-efficacy in Service Improvement Enablement*' (Figure 27, p. 249). This model provides an original contribution to the contemporary evidence base that informs how student and registered nurses experience service improvement in nursing, developing self-efficacy in their ability to make improvements. Self-efficacy is when an individual develops the confidence, self-belief and ability to accomplish a goal or task (Bandura, 1997a; Potter & Perry, 2001; Snyder & Lopez, 2007).

In nursing, self-efficacy is influenced by environmental experiences, depending on the task being asked (Levett-Jones et al., 2009b; Gibbons et al., 2011; Chesser-Smyth & Long, 2013). The concept of socialisation in nursing was a significant feature in my findings, which provide further insight into the factors influencing socialisation of student and registered nurses in practice. The findings have been considered using a social constructivist lens, which supports the understanding of the social context through which service improvement learning and practice in nursing occurs. The importance of fitting in and having a sense of belonging was a key feature of the learning environment. There was evidence that status, hierarchy and feelings of belonging and fitting in affected the experiences of participants. The findings provide further understanding of the pressures that student nurses experience when they do not fit in to the nursing team.

Some participants described how challenges in fitting had a negative impact on their professional socialisation. Lower status and feelings of powerlessness were apparent for participants as student nurses and this reduced their ability make service improvements. The participants encountered barriers, which prevented their service improvements from progressing, including resistance by staff, a perceived lack of time and the lack of student's status within the workforce.

My new '*Model of Self-efficacy in Service Improvement Enablement*', proposes that as the participants progressed along a trajectory from student to registrant, they underwent developmental processes through adapting their behaviours; 'playing the game to fit in' as a way to assimilate into the team and make service improvements. Examples included using casual conversation and offering to help as ways the participants engaged with colleagues in order to be accepted in the team. When the participants became registered nurses, their perceptions of fitting in had changed. The findings demonstrate the use of the word 'we' which illustrates that participants felt part of a wider team, as they discussed the importance of positive socialisation and developing personal relationship with colleagues in being an important feature of becoming empowered to make improvements.

A new finding that emerged from my study was that participant learning about the theoretical aspects of service improvement was sustained into their newly registered period. Participants constructed their own understanding of service improvement based on their iterative experiences within their social context; alongside mentors, colleagues and ward managers. As registered nurses, the participants expanded on their personal construct of service improvement, considering the wider context of service improvement in nursing. This expansion of understanding can be conceptualised through the theoretical lens of professional development as a construct.



Another important finding to emerge from this study was that there was a pivotal learning point when the participants made the transition from student to registered nurse. Some participants described transition shock during their newly qualified period. As participants transformed from student to registered nurses, they developed resilience in order to cope with and adapt to the challenges faced in making service improvements. When the participants became registered nurses, their status was greater, than as a student. As newly registered nurses, the participants demonstrated an awareness of becoming empowered which they attributed to their personal influence, power and professional responsibility to make service improvements.

As discussed, the role of the ward manager emerged as a key feature in empowering the participants to make improvements. The ward manager was important in maintaining a conducive learning environment, facilitating service improvements through their authority and challenging barriers to change. Participants described seeking their ward manager's support that was central to changing practice. The participants described the ward manager as having the authority and power to make changes. When participants felt that they lacked power, they used the ward manager's influence and power to make changes. These findings reflect the theoretical influence of this thesis; power can be viewed from a poststructuralist lens (Foucault, 1995) and is an important concept in nursing (Kuokkanen & Leino-Kilpi, 2000; Bradbury-Jones et al., 2008).

The participants as both student and registered nurses described the ward manager as a role model who encouraged a culture where staff could approach them about their service improvement ideas and ask for advice about making changes in practice. It was evident from the findings that some staff were perceived as being a barrier to change. Participants described staff being reluctant to change practice due to established nursing routines and rituals. Other barriers included time constraints, competing clinical priorities and potential cost implications of service improvements, as reasons why there was resistance to change

practice. The role of the ward manager was critical in overcoming these barriers and in making service improvements.

The findings in this thesis provide evidence of the importance of a positive learning environment which supports learning in practice. There are examples of how feedback and support facilitated the participants in being successful in their learning and practice of service improvement. Positive mentoring experiences helped participants to develop self-confidence in making service improvements. Interactions with effective role models were a key feature in the participant's experiences and learning. The findings provide evidence of how student and newly registered nurses value colleagues, mentors and ward managers whom they consider as positive role models. Participants identified positive characteristics, which they recognised in these people, and they went on to emulate these positive characteristics and behaviours. These findings can be conceptualised through adult and social learning as a theoretical lens. The participants described how they valued informal and formal structures of support including preceptorship and forums where they could share their ideas for service improvements. Mentors and academic staff can help students develop survival skills including reflexivity, self-care, conflict resolution and debriefing with peers and clinical staff (O'Mara et al., 2103). These mechanisms supported participants in developing reflective practice and lifelong learning, through sharing their ideas and gauging support for service improvement. Participants described appreciating forums where were able take their service improvement ideas. Dialogue with colleagues who included research nurses, doctors, ward managers and peers was described as a positive feature to their learning and experiences. This collaborative approach facilitated discussion about service improvements and gave the participants an opportunity to share ideas, receive feedback and progress service improvements ideas. Participants considered these colleagues as positive role models, who they valued and emulated. Staff who are motivated to change are seen as enablers in encouraging the involvement of colleagues in service improvement (Tingle, 2011).

It was evident that participants became empowered and developed self-efficacy in their abilities to make service improvement through positive experiences with supportive mentors and colleagues.

The findings highlighted how some participants had an opportunity to develop their knowledge and skills of service improvement through a preceptorship programme. The participants valued their preceptorship programme as an opportunity to consolidate their learning and practice in service improvements. These findings support studies which found that nurse-led service improvement requires knowledge and skills that must be taught and practiced in order to be successful (Wilcock & Carr, 2001; Christiansen & Griffith-Evans, 2010). As the participants progressed through their preceptorship period, they increased their experiences, confidence and self-belief in making service improvements. Participants described service improvement as important in delivering evidence based, high quality service. A new feature, which emerged from the findings, was the importance of service improvement as a mechanism to promote quality and innovation. Participants believed that service improvement was a measure as to how their NHS Trust was rated and perceived by others.

#### **8.4 Demonstrating reflexivity**

Reflexivity is an important aspect in qualitative research (Shaw, 2010; Clarke & Braun, 2013). Reflexivity considers an interpretivist ontology that sees people and the world as interrelated and engaged in a dialogic relationship that constructs multiple versions of reality (Shaw, 2010). This thesis is based on the premise that all facts are interpreted and previous knowledge is co-constructed to create new knowledge (Heidegger, 1962). This:

*“active acknowledgement by the researcher that his/her own actions and decisions will inevitably impact on upon the meaning and context of the experience under investigation”* (Horsburgh, 2003, p. 308)

Finlay & Gough (2003) suggest that reflexivity is an immediate and dynamic process of self-awareness, which helps situate the research in context. Gergen (1973) however, cautions that reflexivity can be threatened by 'feedback and static' within the research scenario. Nevertheless, the significance of reflexivity in self-awareness and transparency in helping researchers identify influences that may affect data collection and analysis is recognised (Clancy, 2013). With hermeneutic phenomenology, reflexivity can add value to interpretation of findings (Sloan & Bowe, 2014).

Reflexivity and critical reflection on the research process includes reflecting on one's role as researcher, which includes insider and outsider positions. (Clarke & Braun, 2013). Reflexivity was facilitated during my research journey through several processes. Firstly, I maintained reflexive notes during data collection. During the interviews, I used member checking as a way to clarify meanings and interpretations with the participants, noting my thought processes and feelings during the interviews (Figure 13, p. 132). I deliberated on my interactions within the research process, reflecting on my actions and thoughts especially during the interviews. I recognised occasions when I was aware of the danger of projecting my own thoughts and beliefs of service improvement, rather than ensuring the participant's voice was heard. This process of immediate and dynamic process self-awareness (Gough, 2003) allowed me to evaluate my skills and confidence as a researcher.

Another process that evidences reflexivity is my research journal. Ortlipp (2008) suggests that reflective journals are useful for researchers to explore the impact of critical self-reflection on research design and engage with the notion of creating transparency in the research process. My research journal helped me develop a critical understanding of issues and concerns identified during this research. I used the journal to note my thoughts about methodological considerations, conceptual development and my development as a novice researcher.

Reflexivity describes the process researchers go through to become conscious of and reflective about the ways in which their questions, methods and position might impact on the data or the psychological knowledge produced in the research (Sloan & Bowe, 2014). Through being reflexive, I have been able to be truly critical and analytical in some of the decisions I have made. My research journal provided me the opportunity to challenge my thoughts and experiences and evidences an audit trail of decisions and thoughts within the text.

Monthly PhD supervision with my research supervisors was a regular and systematic process where I was able to discuss and reflect on the research processes. My supervision was a forum for discourse and challenge; requiring me to demonstrate how robust my research decisions were. I also found it useful to reflect on the impact my supervisors had on me. I considered them role models, passionate and educated about research and I valued their feedback and the opportunity to discuss my study in an environment where I felt supported and valued.

Keen and Todres (2007) stress the importance of disseminating research findings to a wide audience. Presenting my study through a poster presentation at the RCN International Research Conference (Appendix 13) presented a challenge. The conference meant that my study was open to public and peer scrutiny. Through presenting my poster and receiving feedback from other researchers and nurses, I was challenged to be reflexive and revisit my initial findings and assumptions. van Manen (1997) refers to this as hermeneutic alertness, where researchers do not accept pre-conceptions or interpretations, rather they reflect on the meanings conveyed in order to develop interpretive understanding. I revisited my initial interpretation of the findings, strengthening my thesis (Kvale, 2011). Through deeper analysis, I was able to develop my new model explaining self-efficacy in service improvement enablement through this process.

## 8.5 Original contribution to knowledge

The original contribution that this thesis brings to the existing knowledge base informing service improvement in nursing, is summarised below:

This thesis presents a new '*Model of Self-efficacy in Service Improvement Enablement*' which provides a unique hermeneutic understanding of service improvement experiences of nurses as they make the transition from student to registered nurse. The model provides a framework from which to understand how student and registered nurses develop the self-efficacy needed to make service improvements in nursing. The findings identified seven positive adaptive behaviours, that enabled the participants to professionally transform, become empowered and develop resilience in making service improvements in nursing. The positive adaptive behaviours which the participants acquired were informed by the four sources of information necessary for determining self-efficacy. The findings have been considered through using social constructivism, power, social and adult learning theory and professional development as a theoretical lens, highlighting the importance of the social context, support and relationships within nursing. The findings demonstrated that relationships and feeling part of a wider team provided a forum from which discussion, support and encouragement for service improvements occurred.

My new '*Model of Self-efficacy in Service Improvement Enablement*' could be useful to educationalists, nurses and healthcare organisations to inform service improvement development for the benefit of healthcare service users, patients and families in other healthcare contexts. The next section proposes specific recommendations arising from my study.

## 8.6 Recommendations

### 8.6.1 Recommendations for Pre-registration nurse education

HEI's should continue to build on existing service improvement modules within pre-registration nursing programmes. Using the '*Model of Self-efficacy in Service Improvement Enablement*' as part of a spiral curriculum, will support the student's development of positive adaptive behaviour towards their service improvement capability. The four sources of information could be written into reflective portfolios for example, to enable students to explicitly draw on all available feedback on their service improvement learning. The concept of service improvement could be introduced incrementally to students from first year; sequentially embedding learning and practice. This scaffolding approach to learning would prepare students gradually, allowing them time to develop new knowledge and understanding of service improvements practice and consolidate this throughout their pre-registration programme.

Socialisation within healthcare organisations was shown to be important in facilitating how student nurses made service improvements in nursing. Developing team integration and team building exercises may be a strategy used to help student nurses fit into the nursing and multi-disciplinary teams and become more successful in clinical practice.

This study identified the importance of staff who were motivated, interested and committed to make service improvements. It would be useful if Practice Placement Facilitators, academic staff and ward managers could identify mentors who have been evaluated by students as positive role models and facilitators of service improvements. These mentors could then be encouraged to develop their service improvement skills further through

clinical supervision and appraisal incorporating the Knowledge and Skills Framework (KSF) (Great Britain, Department of Health, 2003).

The participants in this study were seen to use reflective practice during the process of becoming enabled in making service improvements in nursing. Considering the social constructivist approach of Vygotsky (1978), reflection on progress reinforces learning. Therefore, it would be useful for academic staff and mentors to encourage student nurses to develop reflective practice. Students could be actively encouraged to use critical incident analysis, debriefing and peer support as mechanisms to facilitate development of reflective practice skills and evidence their service improvement learning.

#### ***8.6.2 Recommendations for nursing practice***

In this study, role transition was a challenging time for participants, where service improvement learning and practice were not seen as being a priority within the scope of other challenges faced as newly registered nurses. HEI's could work in partnership with placement providers to develop programmes to better prepare students through identifying challenges in role transition before registration. Using the '*Model of Self-efficacy in Service Improvement Enablement*' as a framework, HEI's could better facilitate student nurses' learning of strategies to cope with the competing demands of clinical practice, pressures of time, juggling clinical priorities and addressing knowledge deficits, alongside the requirement to make service improvements.

Some participants described preceptorship as a mechanism which supported their service improvement learning and practice during their newly registered period. HEI's could develop more integrated partnerships with local NHS Trusts and healthcare organisations in order to embed preceptorship programmes for newly registered nurses, which incorporate service improvement as a key objective. Mentors, academic staff and practice



placement facilitators could work across organisations to provide consistency and help newly registered nurses to consolidate their practice.

The current preceptorship period is set out as guidance only (Great Britain. Department of Health, 2010c). However, preceptorship could become a mandatory requirement for all newly registered nurses in healthcare organisations. The preceptorship programme could cover a minimum period of twelve months. After this, service improvement learning and practice can be monitored through robust appraisal systems, linked to the Knowledge and Skills Framework (KSF) (Great Britain, Department of Health, 2003).

The role of the ward manager in service improvement is pivotal and needs to be strengthened. Protected time needs to be given to ward managers so they can manage and facilitate service improvements alongside other complex requirements of their role. Additional training could be provided for ward managers on service improvement, including leadership and managerial aspects of leading their team and supporting students and nurses service improvement learning and practice. HEI's and healthcare organisations could work in partnership to develop in-house service improvement education and training for ward managers to access, with protected time given so they can facilitate service improvements in their teams.

### ***8.6.3 Recommendations for future nursing research***

The '*Model of Self-Efficacy in Service Improvement Enablement*' is propositional and context specific. Exploring different healthcare professionals, such as physiotherapists and occupational therapists and the other fields of nursing, is an area for future research. Different social and working contexts and perceptions of service improvement in a wider healthcare arena would enhance understanding. Further testing of the model for its transferability beyond the study context would enable its ongoing development, refinement and efficacy as a tool to inform nurse education, practice and policy.

Research exploring the perceptions of mentors and ward managers would be beneficial in order to explore how they perceive their role in facilitating service improvement for student and registered nurses. Further attention is needed to understand the impact of relationships, team dynamics and socialisation. This could be expanded to explore the learning environment, considering what facilitates and what inhibits nurses' ability to make service improvements.

Finally, further longitudinal research would be useful. This study has explored the experiences of service improvement from student to newly registered nurse; further research that explores the experiences of nurses in making service improvements after their newly registered period (i.e. after 12 months' registration). This may identify any changes in perceptions and experiences of the nurses over a longer period; determining if learning of service improvement theory and practice is sustained and built upon longer term.

#### ***8.6.4 Recommendations for NHS Trust policy development***

In my study, service improvement was seen as an indicator for measuring quality in service delivery. In the NHS Trust involved in this study, service improvement could be better prioritised and consistently measured as a quality performance outcome. In this way, service improvement would be a priority and outcomes would be shared at a strategic level; informing senior management of innovations in practice and identifying any gaps. This strategic involvement may encourage the Trust and other healthcare organisations who draw on my research to facilitate a culture of service improvement, encouraging participation from all staff including student and registered nurses.

It would be useful if a service improvement lead or champion can be identified for each clinical area. This named person would be responsible for taking the service improvement

agenda forward within their clinical area and supporting students during transition to registered nurses and service improvers.

The service improvement lead or champion in the clinical area would require protected time and delegated authority to make service improvements; overcoming barriers identified in this study. Staff involved in service improvement need to have protected time in order to develop service improvements in an environment where time, resources and clinical priorities are not considered as barriers to changing practice. By using existing resources including practice development nurses, research nurses and ward managers this may help develop inclusive clinical service improvement teams; promoting a philosophy and culture of service improvement learning in each clinical area.

## **8.7 Limitations of study**

In order to be transparent and demonstrate trustworthiness, I have identified several limitations of this study.

This research focussed only on adult pre-registration students and these same participants later as registered nurses, and as such, this may be considered a limitation. For example, the other fields of nursing including child, learning disability and mental health were not part of this research. Interpretive research does not claim to be generalisable to the wider population. However, it does provide a 'moderatum generality' where findings can be applied to other studies, where similar individuals share historical and contextual similarities (Williams, 2000, p.130).

The other fields of nursing would be an interesting focus for future research as the social context, culture and clinical environments are different to those of adult nursing. This is not always the case in practice contexts that are not age or health condition specific, for example accident and emergency, primary care or operating theatres.

In addition, the curriculum studied by participants shared many similarities to that studied by the other nursing fields, including inter-professional learning. It is likely therefore that nurses from other fields of nursing will recognise some of the stories adult nursing participants told about their service improvement experience; potentially enabling their own reflections on their service improvement journey.

Nevertheless, this research was specifically designed to explore experiences of service improvement in nursing from adult student to registered nurses. Being a phenomenological study, no attempts have been made to generalise findings beyond the original participants or in their local context. My research was more concerned with presenting rich data and the data being considered as being trustworthy, which has been discussed in Chapter 5. Researchers who place their research within a social constructivist paradigm argue that no two social settings are sufficiently similar to allow naïve or wide-ranging generalisations between the two (Appleton & King, 2002). Indeed, it is implicit in social constructivist research, that researchers make sense of the uniqueness discovered in each new setting under study.

Another limitation of this study was a location specific context. The participants were all allocated placements in one specific local NHS Trust which was involved during Phase Two of this study, when the participants were registered nurses. This decision was a pragmatic consideration in respect to ethical approval. If the sample had included the whole of the pre-registration adult nursing cohort, then ethical approval would have been required across several organisations, as nursing students are allocated placements in at least five local NHS Trusts and other healthcare organisations. This would have been a time consuming process and delayed the progression of this study. Given that there are approximately 300 adult nursing students, a phenomenological study exploring lived experiences in depth would not have been possible.

The use of semi-structured interviews, using a pre-set interview schedule, may also be considered a limitation of this study. However, this form of data collection was chosen as single semi-structured interviews are congruent with the hermeneutic phenomenology and are pragmatic (McConnell-Henry et al., 2011). The questions were open-ended allowing the participants to share their experiences, perceptions and thoughts through rich descriptions of their experiences. The interviews were in context to space and time, consistent with Heidegger's concept of time and being (McConnell-Henry et al., 2011). Some participants went into detail, whereas others were more reserved and provided only short responses to the questions. Nevertheless, the shorter responses were considered equally valid, the data collected was rich and conveyed the participants lived experiences.

Member checking and clarification prompts, for some of the points raised, were used in order to check my understanding and interpretation of what the participants were conveying. I maintained interview notes and recorded my reflexive thoughts during data collection, where I was conscious that I might be unintentionally guiding the interview, through non-verbal body language or my responses. I was also cognisant of my interpretations of the data, focusing on the participant responses rather than my own thoughts and experiences (Figure 13, p. 132).

## **8.8 Plans for dissemination of findings**

Keen and Todres (2007), highlight the importance of dissemination of research findings, which can occur through various forms and forums.

I have already presented my findings through a poster presentation at The RCN (Royal College of Nursing) International Nursing Research Conference in April 2016 (Appendix 13). The peer feedback I received from this conference, allowed me to question my initial interpretations of findings. Through further analysis, my research developed and a new '*Model of Self-efficacy in Service Improvement Enablement*' was developed.

I intend to present at future conferences, both regionally, nationally and internationally. Northumbria University holds an annual Post Graduate Researcher Conference. This is a conference where current postgraduate researchers can present their research to peers as a mechanism for peer review and feedback. I plan to apply for a poster presentation. Using my own University Post Graduate Researcher Conference is a way of disseminating my findings in a local context. This forum will have other nurse educationalists, practitioners and lecturers attending and will be a forum to share my findings and new model of '*Self-efficacy in Service Improvement Enablement*'.

On completion of my study, I have already started the process of submitting my findings for publication in relevant peer reviewed nursing and healthcare journals including Journal of Advanced Nursing, Nurse Education and Nursing Management. These journals are targeted to readers who may have an interest in my findings in context to their own educational and/or healthcare environment.

I have already arranged to share my findings with the NHS Trust involved in this study. I have a meeting planned with the Research Development Lead. At this meeting the findings from my study will form the focus of the discussion. This is an opportunity to work in partnership with the NHS Trust. I am interested in progressing my recommendations for future research and this meeting will be an opportunity for me to propose my future research plans, as a partnership with the NHS Trust.

I am also planning to visit the local NHS Trust to share my findings to the ward managers, service leads the participants who were involved in this study. I will use this as an opportunity to present my recommendations for practice and how these can be introduced and implemented. I am interested in developing a masterclass or teaching programme in

partnership with the NHS Trust which could be used in the preceptorship programme and with ward managers to facilitate service improvement, using my new model '*Self-efficacy in Service Improvement Enablement*' as a framework.

## **8.8 Chapter conclusion**

This chapter has provided a conclusion to this research. I have identified the new and original contribution this research brings to the existing body of knowledge. This study has been insightful; it has illuminated the lived experiences of service improvement for participants from student to registered nurse.

Hermeneutic phenomenology allowed the individual voices of the participants to be heard, alongside my own hermeneutic interpretation of findings.

The complexity of how nurses are able to make service improvements has been explained through my new '*Model of Self-efficacy in Service Improvement Enablement*', (Figure 27, p.249). This model provides a framework from which to understand how nurses undergo processes of professional transformation, becoming empowered and developing resilience in order to make changes in nursing through service improvements. This framework may also resonate with other fields of nursing and healthcare professionals, in different contexts and organisations.

I have provided a detailed reflexive account of my own learning and development during my research journey. By critically reflecting on the findings, several recommendations for future pre-registration nurse education, nursing practice and research have been presented. These recommendations provide realistic and achievable suggestions that could be adopted in order to promote a service improvement agenda within nurse education, practice research and policy.

Nursing needs to be responsive to changes in health care and the current drive for service improvements is a means of promoting cost effectiveness whilst delivering a high quality service for patients. In order for nurses to be able to respond to this agenda, they need to be educated as students and supported in clinical practice as registrants in order to make service improvements. By encouraging, supporting and enabling student and registered nurses to be active in service improvements in nursing, nurses can contribute to improvements that enhance patient's experiences of healthcare. Developing a culture of service improvement in nursing can be facilitated through educated nurses, who are supported to make service improvements despite challenges they may face; making a difference and changing practice to improve patient care and experiences.

Only then, can the aspiration of a healthcare system that does the patient no harm and delivers high quality care to all can be realised.

***“In order to succeed, people need a sense of self-efficacy, to struggle together with resilience to meet the inevitable obstacles and inequities of life”***

***Albert Bandura***



## **Appendices**

## Appendix 1 Invitation Letter



School of Health and Life Sciences

Pre-registration Health Studies

Room M101

Coach Lane Campus

Newcastle upon Tyne NE7 7XA

Tel 0191 2156606

[l.dracup@northumbria.ac.uk](mailto:l.dracup@northumbria.ac.uk)

Date

### INVITATION TO PARTICIPATE IN RESEARCH STUDY

Dear

The aim of the project is to explore your experiences as a student adult nurse undertaking a small scale service improvement project as part of your undergraduate education and then also to explore your experiences with service improvement within the first 6-12 months of you being a qualified nurse working in the NHS.

You are invited to participate in this study. Before you decide you need to understand, why the research is being done and what it would involve from you. The research is not directly funded by Northumbria University however is part of a PhD study.

You are being invited to participate in this study because you are a student adult nurse who has completed a 3rd year module incorporating a small-scale service improvement. A further phase two of this study will be undertaken within 6-12 months of you qualifying as a registered nurse.

Enclosed is an information sheet, which details the research and what you will be required to do if you agree to take part. Please read this carefully. I will contact you via telephone or e-mail to find out if you are interested in taking part in this research. If you are, I will arrange to meet with you to provide further information and to answer any questions you may have.

You will then be offered a few days to consider whether you wish to be involved. If you do get involved, all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours sincerely

Lynn Dracup

## Appendix 2 Letter of Interest



School of Health and Life Sciences

Pre-registration Health Studies

Room M101

Coach Lane Campus

Newcastle upon Tyne NE7 7XA

Tel 0191 2156606

[l.dracup@northumbria.ac.uk](mailto:l.dracup@northumbria.ac.uk)

### Letter of Interest

Dear

Thank you for your consideration to participate within my research entitled:

***“An interpretative phenomenological study exploring the lived experiences in service improvements for student and registered nurses during their pre and post registration clinical practice”***

#### **Please tick the appropriate box**

I am happy to discuss this research further and give Lynn Dracup permission to contact me using my preferred method found below. I give permission (Please initial the box)

☐

I do not wish to participate in the proposed research. Please initial the box

☐

My preferred contact method is .....

Telephone, and my ward contact number is: .....

Email, my email address is: .....

#### **Discussion**

If you have completed the ‘I give permission’ box Lynn Dracup will contact you on receipt of this letter via your preferred method.

Yours sincerely

Lynn Dracup

### Appendix 3 Consent Form Phase One



#### CONSENT FORM PHASE ONE

**Please initial the box**

	<i>YES</i>	<i>NO</i>
I confirm that I have read and understand the information sheet dated..... for the above study	<input type="checkbox"/>	<input type="checkbox"/>
I have had the chance to ask questions about the study and these have been answered to my satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to be interviewed	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my comments to be recorded and my words used in the research	<input type="checkbox"/>	<input type="checkbox"/>
I can withdraw at any time if I change my mind and this will not affect me in any way	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and details will be kept confidential and will not appear in any printed documents	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and details will be kept for Phase 2 of the study. I am happy to have these details to be retained for future contact.	<input type="checkbox"/>	<input type="checkbox"/>

I, ..... [Name of participant]

understand the information presented to me by ..... [Name of researcher]

and agree to take part in the research.

Signature ..... [Participant]

Date .....

Signature ..... [Researcher]

Date .....

## Appendix 4 Research information sheet



School of Health and Life Sciences

Pre-registration Health Studies

Room M101

Coach Lane Campus

Newcastle upon Tyne NE7 7XA

Tel 0191 2156606

[l.dracup@northumbria.ac.uk](mailto:l.dracup@northumbria.ac.uk)

### **Research information sheet**

#### **Research title**

“An interpretative phenomenological study exploring the relationship between taught service improvement in Under Graduate nurse education and adult nurse’s lived experiences in service improvements both pre and post qualifying as part of their clinical practice”

#### **What is the purpose of the study?**

The aim of this project is to explore your experiences with service improvement where you made a small-scale service improvement as part of your nursing studies at university and then your experiences with service improvement as a newly qualified staff nurse in clinical practice.

#### **Why have I been asked to take part in this study?**

You have been asked to take part in this study because you are an adult nursing student who has completed a module as part of your studies that require you to undertake a small-scale service improvement project.

#### **Do I have to take part in the study?**

No, it is up to you to decide if you wish to take part. I will meet with you to discuss the study in more detail. You will also have an opportunity ask any questions you may have.

If you agree to take part, then I will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at any time, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

**What am I being asked to do?**

If you decide to take part in this study you will be invited to participate in an individual interview by myself; this will be audio recorded and last approximately 45 to 60 minutes. A further individual interview by myself will take place in 2014 approximately 12 months later when you are a registered nurse. This will also be audio recorded and last approximately 45 to 60 minutes.

**Are there any disadvantages to taking part?**

I am aware that you may be identifiable due to the nature of the sample chosen, however your name will not be disclosed, and any data generated will be labelled with your unique identifier number. You may also experience the potential inconvenience of having to take part in an interview that may last for up to 60 minutes.

**What are the benefits of taking part?**

Individuals participating in this study will get an opportunity to discuss their experiences of service improvement as student nurses and their experiences once qualified as nurses and working in the NHS. You can include your participation with research as part of your curriculum vitae and as part of preceptorship, clinical supervision, professional development and appraisal.

**My role as researcher**

I will not be involved in any teaching and marking associated with your Pre-Registration Nursing Programme.

**Student disclosure**

If you disclose any issues which could be viewed as impairing your professional suitability for registration e.g. misconduct, convictions or physical or mental health problems, that information may be shared (preferably with your consent) with the relevant Programme Manager [this is a requirement of the NMC's Code of Conduct, Performance and Ethics, 2008]

**CONFIDENTIALITY****Collecting the data**

The data for this study will be collected using a Digital Dictaphone Recorder during the interview. Once the interview has ended, the recording will be transcribed and a written record of our discussions will be created. The data will not contain your name or any personal details and any paper-based record will be securely stored.

**Storage of the interview tapes, transcripts and other papers**

The tape recorder will be transported from the interview venue to my locked office in a lockable briefcase. All data, the recordings and any paper based information will be kept in a locked cupboard at Northumbria University, in my locked office, until the research is completed. Once the study ends, the tapes will be wiped clear. The paper transcription of the interviews will be stored securely in a locked cupboard, in my locked office, at the University. These documents will be anonymous and are marked by a unique identifier (allocated to you by me). Once the study is completed, any paper information will be shredded.

The only individual who will have access to the tapes and papers is myself.

Any information which is produced as part of the dissemination activities associated with the project will not bear your name.

**What will happen to the results of the research study?**

The results will form part of a report, which will be disseminated by myself and will be made available to study participants. The results will also be published in education and health care journals and within a PhD dissertation. You will never be identified in any publication although your words may be published exactly as you said them during the interview.

**Who is funding this study?**

I am self-funding but this research supported by Northumbria University through its programme of staff development and scholarly activity

**Who has reviewed this study?**

The School Research Committee and the and the NHS Trust Research and Development Department have reviewed the proposed research.

**Where can I find further information about the research?**

In the first instance, please contact myself: Lynn Dracup – Principal Investigator (0191) 215 6606

**If you have any questions about this study, please contact**

Dr Alison Machin PhD Supervisor (0191) 215 6375 E-mail [Alison.machin@northumbria.ac.uk](mailto:Alison.machin@northumbria.ac.uk)

**If I take part, can I withdraw from the study later?**

You can withdraw from the study at any time. Simply contact myself to say you would like to withdraw, the details are at the end of this information sheet. Participation or refusal to participate will not affect your progression on the course in any way;

When you indicate your intention to withdraw from this study I will ask you if you would like me to destroy all of the data collected to the point of withdrawal or whether I can continue to use it as anonymous information.

**Complaints**

If you have concerns about any aspect of this study please speak to either me, or my PhD Supervisor (details below).

**Information disclosure**

Lynn Dracup is a Registered Nurse and SCPHN and is governed by the Nursing and Midwifery Council (NMC); I will inform you at the initial meeting of the NMC Code (2008), and also the NMC Raising and Escalating Concerns Regulations (2010).

**Research Team**

Principal Investigator Lynn Dracup Northumbria University

Telephone (0191) 215 660 E-mail [lynn.dracup@northumbria.ac.uk](mailto:lynn.dracup@northumbria.ac.uk)

## Appendix 5 Consent Form Phase Two



**Please initial the box**

	YES	NO
I confirm that I have read and understand the information sheet dated..... for the above study	<input type="checkbox"/>	<input type="checkbox"/>
I have had the chance to ask questions about the study and these have been answered to my satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to be interviewed	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my comments to be recorded and my words used in the research	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw at any time if I change my mind and this will not affect me in any way	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and details will be kept confidential and will not appear in any printed documents	<input type="checkbox"/>	<input type="checkbox"/>

I ..... [Name of participant] understand

the information presented to me by ..... [Name of researcher] and agree to take part in the research.

Signature ..... [Participant]

Date .....

Signature ..... [Researcher]

Date .....



## Appendix 6 Thank you letter



School of Health and Life Sciences

Pre-registration Health Studies

Room M101

Coach Lane Campus

Newcastle upon Tyne NE7 7XA

Tel 0191 2156606

[l.dracup@northumbria.ac.uk](mailto:l.dracup@northumbria.ac.uk)

Dear

Thank you for your participation within my research entitled;

***“An interpretative phenomenological study exploring the relationship between taught service improvement in UG nurse education and adult nurse’s lived experiences in service improvements both pre and post qualifying as part of their clinical practice”***

The results will form part of a report which will be disseminated by myself and will be made available to you.

The results will also be published in education and health care journals and within a PhD thesis. You will never be identified in any publication, although your words may be published exactly as you said them during the interview.

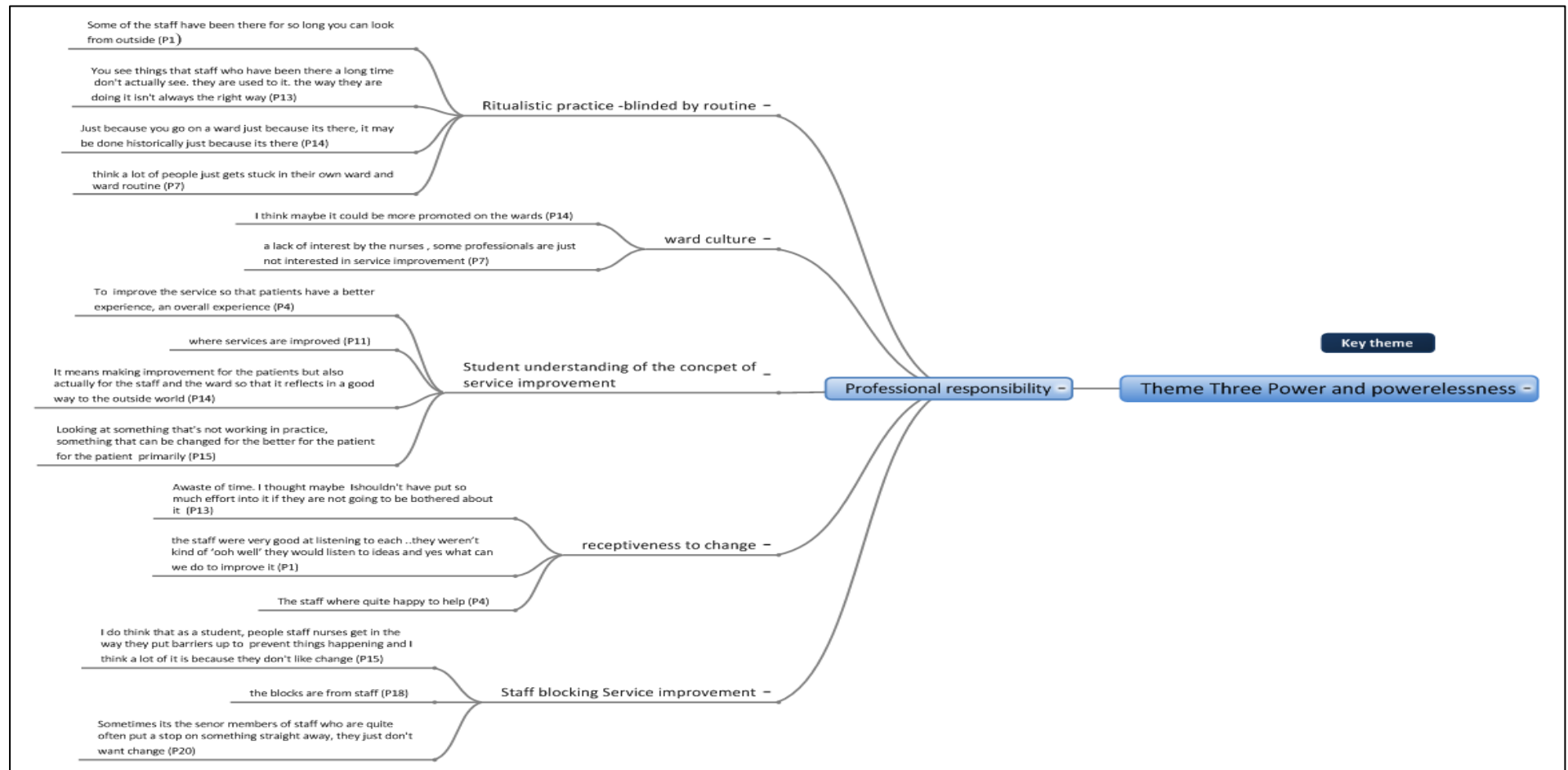
If you have any concerns or queries in regard to your participation, please do not hesitate to contact me on;

Tel (0191) 2156606 Email [l.dracup@northumbria.ac.uk](mailto:l.dracup@northumbria.ac.uk)

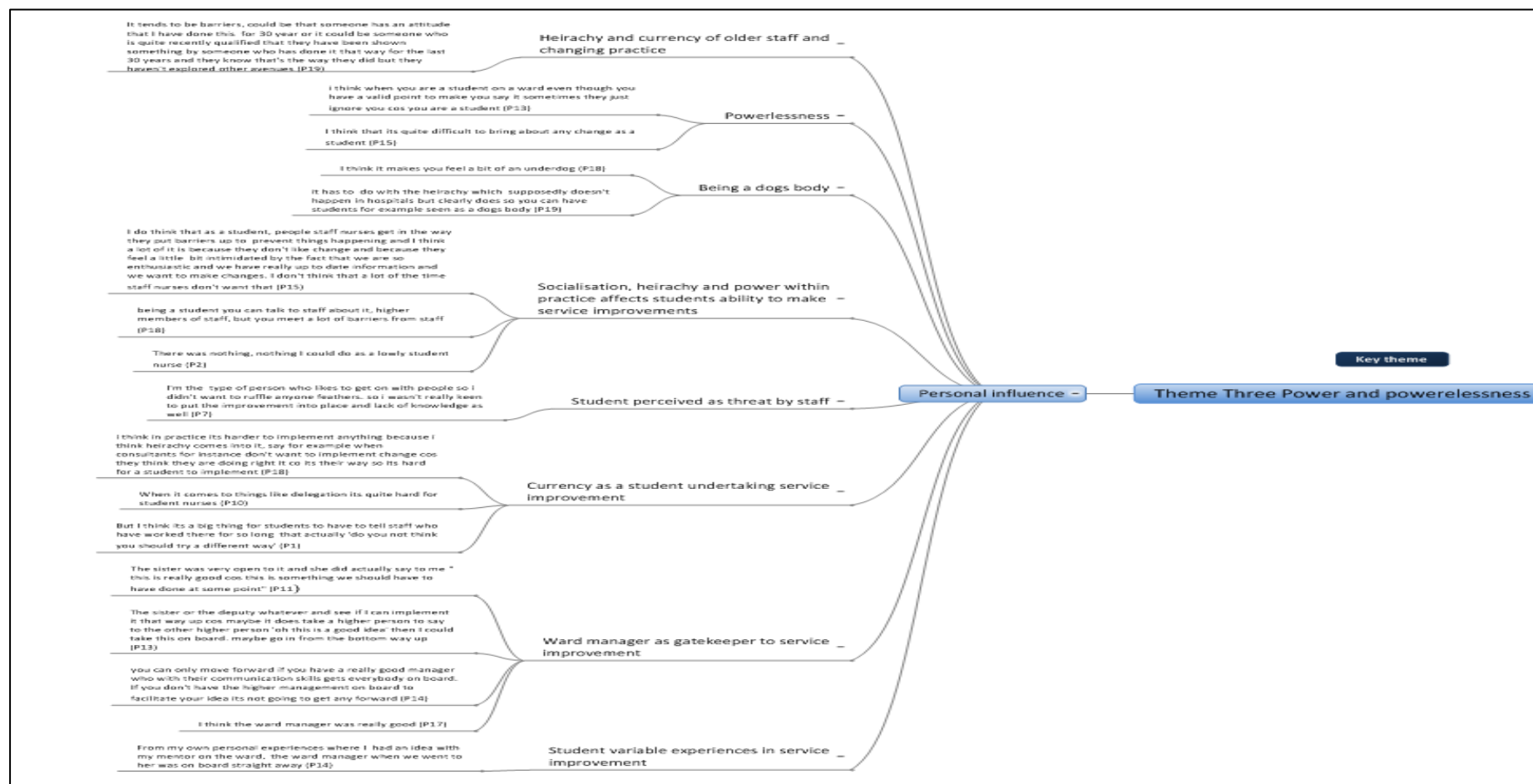
PhD supervisor. Dr Alison Machin. Tel (0191) 215 6375

E-mail [Alison.machin@northumbria.ac.uk](mailto:Alison.machin@northumbria.ac.uk)

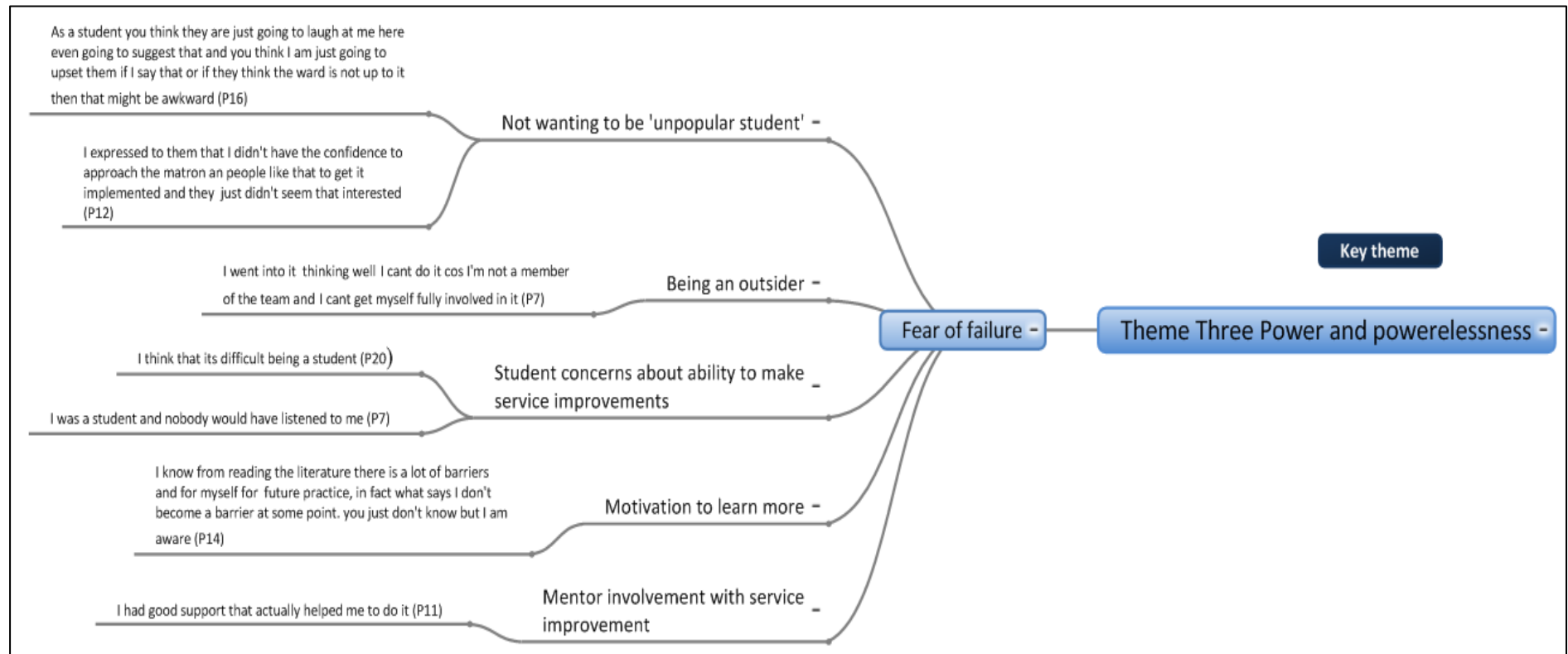
## Appendix 7 Theme Three development; Professional responsibility



## Appendix 8 Theme Three development; Personal influence



## Appendix 9 Theme Three development; Fear of failure



## Appendix 10 Transcript of Participant 7 (Interview One)

1 R. Can you tell me what service improvement (SI) means to you?

2 P1. *Erm well looking at the project we are doing now. It's looking at what's going on*  
3 *in the working conditions. What service users are looking for and making them happy*  
4 *and trying to improve the basics of those kinds of things is what I think it is.*

5 R. Ok what do you understand about service improvement theory?

6 P1. *Erm...probably not very much if I'm truthful (laughs then pauses).*

7 R. Ok. Have you looked at service improvement theory as part of your service  
8 improvement project? What have you been taught at university? Do you know how to  
9 undertake service improvements?

10 P1. *I think you need to go looking yourself. I have finished my service improvement*  
11 *project but I haven't looked in detail very much yet, I've been doing at statistics and*  
12 *other things for it so yeah, I think there are times when you do learn something here*  
13 *(university) but you do have to go find something more for yourself.*

14 R1 yes. can you tell me about that?

15 P1. *Just to get it so you can understand it more and sometimes its not long enough just*  
16 *in a lecture or...(pause) you have to read a lot about stuff yourself and keep learning.*

17 R. Yes ok then that is from a theoretical perspective. Can you now tell me about your  
18 experience of service improvement from a practice perspective?

19 P1. *Can I talk about my SI or do you want other examples?*

20 R. Yes you can talk about your SI or any other experiences you may have had of SI.  
21 Maybe where you have been involved or been aware of SI happening in a clinical area  
22 where you have been on placement?

23 P1. *Right. Ok ...well there were a couple... on this ward where I've just been on ...my*  
24 *project is erm ... you know what's it's like yourself when you do handover and you*  
25 *have names and everything else you are scribbling down. Then it comes to the tea*  
26 *trolley coming and you are trying to find your handover...who is NMB and who needs*  
27 *assistance with food, so the idea I came up with was actually because another staff*  
28 *nurse came on our ward to help out and se put a little white board on the door of the*  
29 *bay, with the names on and a little box. Just a ticky box...is the NBM do they need*  
30 *assistance. So you are not going looking for that handover, you haven't got somebody*  
31 *coming on the late shift who only gets the handover for their bay...which they*  
32 *shouldn't...but...it happens.... erm... are not asking the patient who then doesn't know*  
33 *or they tell you the working information. You know drug errors all that sort of thing*  
34 *can occur ....and this staff nurse had it happening on her ward and she said it worked*  
35 *great. So that was where my idea came from. So once handover is finished the nurse*  
36 *who is in charge of that bay does her white board and there it is in front of your trolley*

37 *when you come to do the food...erm and it just seemed to...everybody would erm... it*  
38 *was like. Yes, we need something...these handovers are no good...and it was that erm*  
39 *a couple of times people go the wrong meals and it all came from there.*

40 *Erm...the other one was...we had 4 bays and 6 one bedded cubicles and they would*  
41 *have one nurse per 2 bays each and then split the cubicles and a HCA mingled around*  
42 *and sort of ...and they actually... by the time I finished on the ward... they had a HCA*  
43 *for each bay who stayed in that bay all day. With their own 6 patients rather than*  
44 *coming and going... you know...say 'you start there 'and 'I'll start there' and not*  
45 *knowing who's doing which jobs...who's done what obs...who's done what*  
46 *washes...they actually had their six patients for themselves for that shift. And they*  
47 *found it much better. They knew their patients and the patients knew their little HCA*  
48 *as well. Their name...as quite often that's hard to remember as well isn't it. So there*  
49 *was kind of the two things happening in the little time I was there.*

50 R. Oh OK. Yes, can you please tell me about your experiences of how your SI  
51 where...how where they on the ward...where they accepted, where people receptive?

52 P1. *They were very receptive to both because things were going wrong erm people*  
53 *were getting the wrong meals ...erm some of the patients had dementia. They couldn't*  
54 *tell you if they needed help or where NBM. Erm...they were getting left with the meal*  
55 *not being assisted or...obviously, things like that shouldn't happen but we know quite*  
56 *often it does when you only have a HCA on running between two bays. And I think the*  
57 *HCA each bay came from the sister ...she said something needs doing here. Where you*  
58 *know these things are happening...so she put that in and the rest of the staff as far as*  
59 *the little white board where very receptive to it...because they were getting the... you*  
60 *know ... if you were a student or a HCA the qualified staff didn't have time for you to*  
61 *come and say can I check with your handover. Have you changed their NBM status or*  
62 *whatever...so having it (The white board) for the few seconds it took each time there*  
63 *was a handover to update it they were quite happy?*

64 R. why do you think that was... why do you think them where so receptive?

65 P1. *I think because things weren't right anyhow.... erm it came from another staff*  
66 *nurse not just me kind of. The conversation came 'that it works on our ward' so they*  
67 *thought well shall we give it a try as well. Erm and plus the staff were very good at*  
68 *listening to each. they weren't kind of 'ooh well' they would listen to ideas and yes*  
69 *what can we do to improve it. it was such a busy ward as well, they knew they didn't*  
70 *have that extra...you know sometimes extra half an hour...sometimes you would get to*  
71 *the very bottom cubicles and think these meals are getting cold and you hadn't finished*  
72 *them. Whereas when you had the chart you could just look there and it was taking no*  
73 *time. It was sometimes taking for or five of us having to serve just to get through the*  
74 *meals, whereas with the chart you just needed a couple to get though the meals.*

75 R. so in terms of your experiences in this project, can you tell me what knowledge and  
76 skills you think that you need in order to facilitate service improvement in practice?

77 P1. *It was an issue of funding. So that's needed for you to even think to say 'I have an*  
78 *idea for a service improvement'. You need to have some background first erm I think*

79 *you need to know the background. Obviously, I was looking at the patients being erm*  
80 *they were quite timid when you were asking them about needing assistance with meals,*  
81 *some would answer you willingly, some would give you the wrong information. Some*  
82 *couldn't tell you as poor things they had dementia or things like that. So you need to*  
83 *know a little bit of background to those kind of things. Also drug errors could occur*  
84 *and it was time management, which is an issue of funding. So all those are needed for*  
85 *you to even think to say 'I have an idea for a service improvement'. You need to have*  
86 *some background first.*

87 R. So how did that make you feel about facilitating service improvement?

88 P1. *Horrible...horrible*

89 R. Why is that? Can you explain what you mean for me?

90 P1. *I was alright with the people I was with but to go on a placement with all these*  
91 *qualified staff and say 'actually I have an idea', your kind of don't want to you feel*  
92 *like they will go 'too look at her', you know just being the student and so it's like which*  
93 *way round will we do this. But I was quite lucky, there were 3 students and we all*  
94 *chatted about assignments and we all said we have to look at service improvement,*  
95 *and we sort of brought it around that way instead. Rather than going and saying 'I*  
96 *have to implement this', I don't think I would have been able to. I think I would have*  
97 *just shied away from it.*

98 R. Can you explain why was that?

99 P1. *Just for someone to go 'oh. That won't work'. You know we had the talks in the*  
100 *seminars about how you need to access MDT meetings and I kept thinking I don't want*  
101 *anything too big where I have to do all of that. In case it all goes wrong and I can't do*  
102 *my project. Do you know what I mean? So for me I don't find it easy to go in and say*  
103 *I have an idea.*

104 R. So has that changed since you have now completed your service improvement? If  
105 people were really receptive and it worked. Has that changed your thoughts maybe  
106 about service improvement and how you would do things perhaps differently in the  
107 future?

108 P1. *Erm yeah...maybe sort of how I would approach it. How I did like just casually*  
109 *chatting like I did about it. I would maybe stick to that way again. Yeah...*

110 R. Ok why was that? Was it because it worked?

111 P1. *Yeah ...*

112 R. You would use that approach again? Can you explain a bit more for me?

113 P1. *Yeah, I would say it more casually, like not just saying 'do you know what you*  
114 *should do on this ward... or 'this would be better', just casually saying.... 'do you think*  
115 *there is a problem? Obviously, we have to do a project; you cannot when you are a*

116 *staff nurse. Maybe just saying I have not been here very long, do you have problems*  
117 *with this... you know...just informally chatting.*

118 R. Ok.... yes....

119 P1. *That would be the way I would do it...*

120 R. Why would you do it that way though?

121 P1. *I just think sometimes. I felt as if they weren't interested in me, that they mightn't*  
122 *like me suggesting stuff they think is ok. By being sort of casual, it's not challenging*  
123 *its just asking in a quiet way.*

124 R. can you tell me a little more about that?

125 P1. *I just think that it's less threatening to come in and appear like you know everything*  
126 *or are judging them.*


127 R. Ok that is great, anything else you would like to add about your service  
128 improvement experiences?

129 P1. *No not at the minute, that's all thanks*

130 R. Can I just thank you for your time, honesty and for taking part in my study? That is  
131 much appreciated



## Appendix 11 Northumbria University ethical approval letter

<p>Lynn Dracup Northumbria University Faculty of Health &amp; Life Sciences Coach Lane Campus Newcastle upon Tyne NE7 7XA</p>	 <p><b>northumbria</b> <b>UNIVERSITY</b></p>
	<p><i>Professor Kathleen McCourt CBE FRCN</i> Dean</p>
	<p>This matter is being dealt with by: Professor Olivier Sparagano Associate Dean Faculty of Health and Life Sciences Research &amp; Innovation Office Room H007 Coach Lane Campus East Newcastle upon Tyne, NE7 7XA</p>
	<p>Tel: 0191 2156480 Fax: 0191 2156083 Email: <a href="mailto:julie.blackwell@northumbria.ac.uk">julie.blackwell@northumbria.ac.uk</a></p>
<p>14<sup>th</sup> December 2012</p>	
<p>Dear Lynn</p>	
<p>Faculty of Health and Life Sciences Research Ethics Review Panel Title: An interpretative phenomenological study exploring the relationship between taught service improvement in UG nurse education and adult nurses' lived experiences in service improvements both pre and post qualifying as part of their clinical practice</p>	
<p>Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent CRB and occupational health clearance if your research involves working with children and/or vulnerable adults.</p>	
<p>The University's Policies and Procedures are available from the following web link: <a href="http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard">http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard</a></p>	
<p>You may now also proceed with your application (if applicable) to:</p> <ul style="list-style-type: none"><li>• NHS R&amp;D organisations for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).</li><li>• Research Ethics Committee (REC). [They will require a copy of this letter plus the ethics panel comments and your response to those comments]. If your research is subject to external REC approval, a 'favourable opinion' must be obtained prior to commencing your research. You must notify the University of the date of that favourable opinion.</li></ul>	
<p>You must not commence your research until you have obtained all necessary external approvals.</p>	
<p>Both the University and NRES strongly advise that the supervisor accompany the student when attending an external REC.</p>	
<p>All researchers must also notify this office of the following:</p> <ul style="list-style-type: none"><li>• Commencement of the study;</li><li>• Actual completion date of the study;</li><li>• Any significant changes to the study design;</li><li>• Any incidents which have an adverse effect on participants, researchers or study outcomes;</li><li>• Any suspension or abandonment of the study;</li><li>• All funding, awards and grants pertaining to this study, whether commercial or non-commercial;</li><li>• All publications and/or conference presentations of the findings of the study.</li></ul>	
<p>We wish you well in your research endeavours.</p>	
<p>Yours sincerely</p>	
<p>Professor Mina Cattani Chair, Faculty Research Ethics Review Panel</p>	<p><i>Vice-Chancellor and Chief Executive</i> Professor Andrew Wathey</p>
<p>Northumbria University is the trading name of the University of Northumbria at Newcastle</p>	

## Appendix 12 NHS Trust ethical approval letter

Nursing and Patient Services Director Mrs Helen Lamont  
Patient Services PA Mrs Diane Cree

Tel: 0191 233 6161  
Fax: 0191 2131968

Ref: HL/DEC

5<sup>th</sup> February 2013

Lynn Dracup  
Senior lecturer  
Northumbria University  
Faculty of Health and Life Sciences  
Coach Lane Campus  
Newcastle upon Tyne NE7 7XA

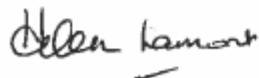
Dear Lynn

***An interpretative phenomenological study exploring the relationship between taught service improvement in UG nurse education and adult nurses' lived experiences in service improvements both pre and post qualifying as part of their clinical practice.***

Thank you for all the relevant documentation which you have forwarded to Dr Walls regarding your proposed study, and for our telephone conversation earlier this week. As I explained, Dr Walls is currently on leave and, as this is a Nursing study, this has been passed to me for response.

I am happy to support your request and to provide authorisation for this study to go ahead with Nurses employed by the Newcastle Hospitals. Clearly, at the time these interviews are to take place is to take place we will need to confirm that the relevant access arrangements are in place. Please come back to me at that time so we can ensure the necessary arrangements. In the meantime please do not hesitate to contact me if I can be of further help

Yours sincerely



Helen Lamont  
Nursing and Patient Services Director

Cc Dr T J Walls Medical Director

## Appendix 13 RCN Brochure and poster 53



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The brochure features a purple background. In the center, there is a black and white photograph of three women in nursing uniforms. One woman is looking at a laptop, another is looking at a tablet, and the third is smiling. The text is in white, and the RCN logo is in the top right corner.

# Book of abstracts



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mentors, senior students and the interdisciplinary team were viewed as crucial.

**Discussion and Conclusion:** Preparing students for their first practice placement is recognised as a crucial time when the student is formally welcomed to the clinical area. Integral to this is collaborative working by both clinical and HEI staff. This paper offers some activities to prepare students for their first practice experience in the future.

#### Poster 53

### **(36) An hermeneutic phenomenological study exploring service improvement experiences for undergraduate adult nurses and in their post qualifying clinical practice**

*Lynn Craig, Northumbria University, Newcastle, UK*

#### **Abstract**

**Background:** High quality, safe and effective health care is vital. Recently health care has experienced a significant growth and prioritisation of service improvement. Nurse's role in service improvement is fundamental. In order to contribute to this at a foundational level, nurses must be prepared within undergraduate education and also in post registration practice.

**Aims:** To explore service improvement through the lived experiences of undergraduate adult nurses, and later, as registered nurses.

**Method:** Hermeneutic phenomenology. 20 participants were purposively sampled, typifying the adult pre-registration nursing profile. Data collection was 2 in-depth semi structured interviews. Interview 1, 3rd year of their undergraduate adult nursing programme (January 2013). Interview 2, 12 months post registration (April 2014).

**Results:** 4 themes emerged. 1: Making sense of service improvement with subthemes of 'a personal construction of service improvement', 'linking theory to practice' and 'seeing a need for service improvement'. 2: Socialisation; a sense of Belonging, with subthemes of a desire to 'fit in', 'maintaining the status quo' and 'role transition'. 3: Power and powerlessness, with 'personal influence', 'fear of failure' and 'professional responsibility' as sub themes. Finally 4: Change theories in nursing practice, includes sub themes of 'facilitators and resistors to change', 'currency of staff', 'ritual and practice' and 'developing confidence to change'.

**Conclusion:** Three interlinked themes of self-efficacy, empowerment and resilience developed for participants as they underwent role transition from undergraduate nurses to registrants. This transition evidences social constructivism, where experiences and interactions have

impacted their knowledge acquisition, learning, development of role identify and adoption of the values of nursing. The complexity of service improvement in relation to the transition for undergraduate to registered nurses is demonstrated. The impact of barriers and facilitators of service improvement is seen to promote reflection and learning for participants as they transit through learning and professional development.

#### Poster 54

### **(227) Undergraduate nursing students' experiences with stress in Nigeria.**

*Dr Patience Edoho Samson-Akpan, RN, PhD, Associate Professor, University of Calabar, Calabar, Nigeria*

#### **Abstract**

**Background:** Literature reveals increased stress during medical training (Esti, Radi & Youssri, 2013) including severe symptoms such as depression and acute anxiety (Dahlin, Joneborg & Runeson, 2005). There is however no study in Nigeria addressing stress experiences of undergraduate nursing students.

**Aims of the study:** To examine and explore the lived experiences with stress among undergraduate nursing students in the University of Calabar, Nigeria.

**Methods:** A mixed method (descriptive and Hermeneutic phenomenology) design with 63 Direct Entry students purposely selected because they were matured and might be more experienced in managing stress. The instrument for data collection was a modified tool from Inventory of College Students' Life Experiences (ICSRLE)(Kohn, Lafreniere & Gurevich, 1990). The instrument has an internal consistency of 0.79 (Cronbach coefficient) and a reliability correlation coefficient ( $r$ ) = 0.77. The qualitative aspect used a focus group discussion involving 15 students out of the sample of 63. Qualitative data were coded and thematically analysed using the Hermeneutic circle, while quantitative data were descriptively analysed using SPSS version 20.0. Data collection (from 8th 19th September, 2015). Ethical approval was obtained from Cross River State Ministry of Health Ethical Committee.

**Results:** The mean age of participants was 34.79±7.10; females 54(85.7), year five 26(41.3%); never married 33(52.4%); 61(96.8%) were living off campus. The respondents 56 (88.9%) and 61(96.8%) said academic stress and interpersonal stress were very much part of their lives in the school. Emerged themes were 'the academic programme is hectic and stressful'; 'poor relationship of lecturers with students'; 'some lecture times are stressful'; 'the environment is not conducive for learning' etc. The coping strategies identified were balancing academics with recreation and avoidance.

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